

Affording Boomer Long-Term Care in Minnesota and the Nation

What Do Demographics and Health Trends Tell Us?



Peter J. Nelson

Center of the American Experiment is a nonpartisan, tax-exempt, public policy and educational institution that brings conservative and free market ideas to bear on the hardest problems facing Minnesota and the nation.

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Executive Summary

How to pay for the retirement of 77 million baby boomers will be an intensifying debate. This report—first in a series of three—examines one slice of the debate: how to meet the escalating long-term care (LTC) needs of the elderly. Specifically, this report examines how the changing demographics and health of the elderly in Minnesota and the nation will impact both the need for LTC and the resources available to provide LTC.

Most LTC reform efforts center on how to get more people to pay for their own LTC. Efforts to encourage greater personal responsibility and more self-financing may indeed be the most important part of the solution, but it is not the only part. Oscillating Twentieth Century birthrates—a cultural phenomenon—is largely responsible for our present problem: Might other cultural shifts and undulations be part of the solution? The demographic and health trends identified in this report suggest yes. The data show that a number of factors, such as a strong work ethic, robust families, fewer widows, and better eating habits, can have real impacts on LTC.

Demographic Trends and Projections Impacting Long-Term Care:

- Projected aging trends in Minnesota mirror national trends. Minnesota's 65 and older population will double between 2000 and 2030, and the median age will rise from 35.4 to 39.0. At 18.9 percent, the percent of those over 65 in 2030 in Minnesota is only slightly lower than the national average. Populations of the oldest of the old in Minnesota—those over 85—will not grow quite as fast as the national average, but they will still nearly double.
- More elderly, without more non-elderly workers paying taxes, means the public burden of LTC will be concentrated on fewer and fewer workers as more and

more boomers retire. The national worker-to-retiree ratio, estimated at 4.98 working-age adults per retiree in 2000, is projected to decline sharply to 2.89 working-age adults by 2030.

- Higher elderly population growth rates in the South and the West will make the burden of LTC more proportionate by creating a more equal distribution of workers-to-retirees across states.
- Retirees moving south do not appear correlated with more LTC needs. The three states with the highest net migration rate for 65- to 74-year olds—Nevada, Arizona, and Florida—also have some of the lowest rates of aged Medicaid beneficiaries.
- Census data suggest that significant numbers of Minnesotans leave for retirement but move back for LTC. Between 1995 and 2000, 20.2 percent of Minnesotans aged 65 to 74 left the state for warmer climates, but for those 85 and over, the migration flow results in a net gain of 9.4 percent.
- If it were not for the dramatic decline in fertility rates experienced in the 1960s and '70s—which fell from a high of 122.7 live births per 1,000 women age 15 to 44 in 1957 to 65.0 in 1976—we might have enough Generation X workers to cover the costs of the boomer generation. Today, the average U.S. family with children under the age of 18 has 1.86 children—not even enough to replace the parents, let alone those who never have children.
- Elderly widows and widowers use LTC at much higher rates, and so any decline in widows and widowers will also result in fewer people needing LTC. Nationally, the rate of elderly widowed women dropped from 49.4 percent to 45.3 percent between 1990 and 2000. For Minnesota

the rate declined by even more from 48.6 to 44.1 percent.

- Like widows and widowers, those who never marry also use LTC at higher rates. Unfortunately, the elderly never-married population will increase in the future and add to the LTC burden.
- Future LTC costs might also be mitigated by the consistent flow of immigrants entering the United States. Already, the foreign-born population in Minnesota contributes a sizable and increasing share of new-born children. During the 1990s, the proportion of births to foreign-born mothers in Minnesota increased from 5.4 percent to 13.4 percent.

The Future Health Status of Aging Baby Boomers:

- Between 1982 and 2004 national surveys report consistently lower rates of people over 50 years old self-assessing their health as poor or fair. Overall, Minnesotans report lower rates of poor or fair health than any other state on the most recent state surveys.
- Life expectancies continue to rise, reflecting an overall improvement in the health of Americans. National life expectancies rose from 68.2 years in 1950 to 77.5 years in 2003, and the life expectancy of those who reach 65 years rose even more dramatically on a proportionate basis, from 13.9 years in 1950 to 18.4 years in 2003. Minnesotans had the second longest life expectancy—79.1 years—in 2000.
- Between 1950 and 2000 death rates among the elderly dropped 42 percent among 65- to 74-year-olds; 39 percent among 75- to 84-year-olds; and 23 percent for those 85 and over. Minnesota's overall death rate—713 per 100,000—trails only Hawaii for the lowest rate in the U.S.
- Combined, Alzheimer's disease, senile dementia, and other mental disorders represent the primary diagnosis for 26.6 percent of all nursing home residents. Because the rate of Alzheimer's increases exponentially with age, and more people will survive other diseases allowing them to live longer with Alzheimer's, the prevalence of Alzheimer's and related conditions will likely quadruple by 2050 unless advances in medical technology intervene.
- Recent surveys show upward ticks in the prevalence of many chronic conditions among the elderly, including hypertension, strokes, asthma, breast cancer, prostate cancer, colon/rectal cancer, lung cancer, melanoma, skin cancer, diabetes, kidney disease, and liver disease. Boomers also experienced increasing rates of many of the same chronic conditions.
- Most research on health status of the elderly focuses on disability as disability directly affects independence and the need for LTC. Since the 1980s, most measures of disability among the elderly have declined, with the most pronounced decline taking place in the 1990s. Likely contributors include: improving medical technology, healthier behavior, increasing use of preventative measures, increasing use of aids, higher education levels, rising wealth, and less exposure to disease. Elderly Minnesotans report both lower disability rates and less severe disabilities.
- Slimming America's waistline would go a long way to soothing fears that disability rates might rise. Nonetheless, obesity rates continue to grow rapidly. Between 1990 and 2002, self-reported obesity in population surveys increased nationally from 11.6 percent to 22.1 percent. For Minnesota the numbers were worse, rising from 10.2 percent to 22.3 percent. Some predict disability rates will start increasing once obese boomers start experiencing the

disabling effects of obesity—diabetes, heart disease, hypertension, cancer, and arthritis—which, if true, will be costly.

- Future cost control depends on the large-scale adoption of preventative measures. Are today's elderly and baby boomers taking the necessary steps to prevent debilitating and costly disease? Yes and no. When the prevention can be had through a doctor's visit or a drug, like cancer screening and cholesterol lowering drugs, the answer is mostly yes. But when prevention requires more day-to-day self discipline, like diet and exercise, the results come in mixed.
- Despite overall health gains, LTC costs may increase if the diseases that create LTC-related needs become more numerous. This fact highlights how important treating the specific diseases that lead to LTC can be in any strategy to keep boomer LTC budgets affordable.
- Longevity will likely increase LTC costs. Studies find that increasing longevity will impact acute care and LTC expenditures quite differently. In general, the studies find that better health might possibly lower lifetime acute care costs, but that it will most likely raise LTC costs.

Looking broadly at what the demographics and the health of the boomers tell us, three lessons stand out.

- First, a strong economy, by keeping people in the workforce and by keeping their salaries growing, will guarantee more public resources to pay for LTC and, at the same time, constrain demand for those public resources.
- Second, larger families also will add to public resources for LTC, as well as lower demand for it, by adding more people to the workforce and increasing the number of informal caregivers.

- Third, the health of boomers and the elderly is generally improving, but we cannot depend on such improvements to lessen the need for LTC. On one hand, they may lead to less need for LTC since they are tied to declines in circulatory system diseases and disability rates, which in turn, precipitate much less need for LTC. On the other hand, and as noted, studies likewise suggest that healthier, longer-living boomers will require *more* LTC.

Some may say that it is too late for policy solutions that address demographic and health issues. The boomers are already at retirement's threshold. But, assuming many boomers won't need LTC until they turn 85, the last of them will begin needing it around 2049, a long way off. Policies and personal practices begun today that make working and building businesses more attractive, that make families more robust, and that reduce health problems would indeed make a difference.

Foreword

Mitchell B. Pearlstein, Ph.D.
Founder & President
Center of the American Experiment

“Affording Boomer Long-Term Care in Minnesota and the Nation” is the first major study in American Experiment’s new multi-year project of research, publications, public programs, and advocacy, “Stopping Boomer Health Care Budgets from Going Bust.” It’s also the first in a trilogy of reports by Peter J. Nelson, to be released in 2007, focusing specifically on hugely expensive issues surrounding LTC.

The two titles above tell only half the stories; subtitles each time tell the rest.

What exactly about “affording” long-term care do we need to learn? To start, as Peter poses the question: “What Do Demographics and Health Trends Tell Us?”

And how, overall, are we to stop boomer budgets from drowning us in red ink and darker dye? The answer here is wordier and the summons tougher, having to do with “The Imperative of Taking Greater Advantage of Markets, Families, and Faith in Assuring First-Rate and Affordable Health Care for the Coming Surge of Seniors.”

Fleshing matters out, why and how must we better rely on free markets, personal responsibility, generous families, and religious organizations if we are to keep immense spending increases as non-crippling as possible in a country with the most expensive health care system in the world already? At root, why and how must citizens retrieve responsibility from governmental agencies for their own well-being and that of loved ones as we grow old?

Unless policy-makers take essential but exceedingly difficult steps, Brian Riedl of the Heritage Foundation, for example, envisions

federal revenues down the road totaling 18 percent of Gross Domestic Product (GDP), while federal (non-interest) *spending* totals 28 percent of GDP. This 10-percentage-point gap, he predicts, would lead to budget deficits large enough to increase the national debt from 40 percent of GDP to more than 300 percent. This, in turn, would “set off a vicious circle of rapidly increasing debt translating into higher net interest spending (exacerbated by higher interest rates), which would increase debt even further—possibly to 500 percent of GDP.” Increases in governmental borrowing of this exponential magnitude, he concludes, would “devastate financial markets and eventually could trigger a financial and economic crisis.”

The only suspect word in this last paragraph is the qualifier “could” in the last sentence, as there’s not the smallest chance that “devastated” financial markets would *not* result in financial and economic crises.

A favorite rhetorical device of polemicists is predicting that if something is not done immediately to constrain governmental spending in a particular area, before long, every dime of public spending will wind up going to it, be the “it” in question health care, corrections, or another big-ticket item. They’re absurd extrapolations, needless to say, which is not to say they can’t illuminate. Riedl, for example, predicts that if nothing is done to change Medicare, Medicaid, and Social Security, by 2045, all federal spending would be consumed by those three programs alone, along with interest on the national debt. At that point, and in keeping with the wishes of a famous bumper sticker, the Pentagon really would have to hold bake sales in order to buy battleships.

Brian Riedl is a very good budget analyst for the Heritage Foundation, which is a very good conservative think tank. How might two very good liberal or centrist economists, under the aegis of the liberal and centrist Brookings Institution (which, like Heritage, is an

exceptional policy organization) describe matters?

With the exact same urgency.

Alice Rivlin and Isabel Sawhill, both of whom held senior positions in the Clinton administration, write of what it will take to meet the “unprecedented challenge” of balancing federal budgets as more than 75 million boomers age. Only three options for doing so exist, they argue: reducing current commitments to senior citizens; “slashing” other governmental programs; or getting the public to “accept” higher taxes.

Relying exclusively on even “draconian cutbacks” in programs like Social Security and Medicare, they write, would be insufficient given the sheer increase in the number of elderly. “Squeezing down” most other federal programs would prove inadequate as well as “detrimental to the well-being of younger families and children.” And if the preferred route is higher taxes, Rivlin and Sawhill estimate that federal tax bills would consume at least another 6 percent of GDP.

None of these choices, whether employed alone or in combination, would be pretty. In fact, it’s tantamount to impossible imagining any of them as politically tenable—at this stage, anyway.

So what to do? What changes in public policies—and perhaps more importantly, in cultural attitudes—are demanded by such severe fiscal prospects? This is what American Experiment seeks to discover and pursue in the next several years, with this first inquiry being a terrific kick-off.

In approach, it’s similar to three publications we released last decade: two on “Leading Cultural Indicators,” in 1994 and 1999; and one on “Leading Environmental Indicators,” also in 1999. Meaning, “Affording Boomer Long-Term Care in Minnesota and the Nation,” is big on reams of data and small on editorializing. It

was conceived as a non-ideological and certainly non-polemical resource for all parties, and that’s exactly what Mr. Nelson has pulled off. I suspect the fact that he was integral in researching and writing the two 1999 Indexes is no accident.

Just one simply fascinating dynamic this time around: “Census numbers suggest that Minnesotans leave for retirement *but move back for long-term care*. Between 1995 and 2000, 20.2 percent of Minnesotans aged 65 to 74 left the state for warmer climates, but for those 85 and over, the migration flow resulted in a net gain of 9.4 percent.” What might be the fiscal implications of this back and forth (really forth and back) movement? While it’s always wonderful to welcome Minnesotans back home, enriching us thereby, if I had to guess, a main implication would be that places like Arizona and Florida are coming out financially gangbusters in the roundtrips.

Peter Nelson, an Edina native, is an American Experiment Policy Fellow. He’s also an attorney, having received his degree from the University of Minnesota Law School, where he served on the *Law Review*. Next up in his three-part package will be a review of additional cost drivers, in Minnesota and countrywide, likely to make long-term care even harder to pay for. To be followed by an analysis of the capacity of both public and private sectors in Minnesota to handle such obligations.

We both trust you will find this first installment useful—no, make that fascinating. And we welcome any comments you may have.

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Introduction

How to pay for the retirement of 77 million baby boomers will be an intensifying debate. This report—first in a series of three—examines one slice of the debate: how to meet the escalating long-term care (LTC) needs of the elderly. Specifically, this report examines how the changing demographics and health of the elderly in Minnesota and the nation will impact both the need for LTC and the resources available to provide it.

Problems surrounding Social Security and Medicare generally garner more exposure than those involving Medicaid, the primary payer of elderly LTC. But Medicaid spending has fully arrived as a serious fiscal issue, even before boomers retire. Medicaid now costs more than Medicare and, on average, accounts for the single largest state budget item. LTC accounts for about a third of Medicaid budgets and will increasingly strain state budgets as more boomers begin needing LTC, a demand that will triple by 2050.

With each year we ignore the fiscal problems of Social Security and Medicare, they become more difficult to solve. If we address Medicaid today, we can actually get ahead of the problem, instead of playing catch-up as we do with Social Security and Medicare.

Medicaid was created in 1965 as a safety net for Americans who couldn't afford basic health care, and for those under 65 it largely remains a safety net. But Medicaid has now become the primary funding source for LTC for the elderly.

Unlike the federally run Social Security and Medicare programs, Medicaid operates as a partnership between federal and state governments. States administer Medicaid and the federal government reimburses between 50 and 80 percent of costs as long as federal guidelines are followed. States must apply for waivers from the federal guidelines to make most reforms.

Ironically, the less-pressing and less-debated Medicaid system recently got a major dose of federal fiscal reform with the passage of the Deficit Reduction Act of 2005 (DRA). The DRA set in motion reforms estimated to save Medicaid \$7 billion over five years and \$28 billion over ten years. The DRA was an extremely positive first step toward keeping Medicaid affordable, but much more must be done to keep boomers from busting state budgets with their doubling of the elderly population.

Most LTC reform efforts center on how to get more people to pay for their own LTC. Efforts to encourage greater personal responsibility and more self-financing may indeed be the most important part of the solution, but it is not the only part. Oscillating Twentieth Century birthrates—a cultural phenomenon—is largely responsible for our present problem: Might other cultural shifts and undulations be part of the solution? The demographic and health trends identified in this report suggest yes. The data show that a number of factors, such as a strong work ethic, robust families, fewer widows, and better eating habits can have real impacts on LTC.

(Note: Two terms will be peppered throughout this report: boomer and elderly. By definition boomers were born between 1946 and 1964. But when comparing statistics, finding data for that exact age range is difficult and most studies and reports cited here pick more even age ranges of ten- or 20-year increments. This report, therefore, often refers to the 45- to 64-year-old age range as boomers, and though not precise, it is the 20-year age bracket that best captures present-day boomers. The report also discusses different elderly age brackets—mostly the 65 to 74, 75 to 84, and 85 and over brackets—but when this report generically refers to elderly, it refers to those 65 and over.)

Demographic Trends and Projections Impacting Long-Term Care

The U.S. population has already begun to age en masse. Between 2005 and 2010, U.S. elderly populations will grow at double the rate of the adult population under 65. Once boomers begin reaching retirement age of 65 in 2011, the elderly population growth rate will rise even more, while the remaining adult population growth rate will slow to a near stall.

The U.S. Census Bureau predicts the population of those 65 and older nationally will double between 2000 and 2030, with the number of those 85 and over more than doubling (see Figure 1).¹ As elderly populations double, adult populations 64 and younger will increase by only 19 percent. This marked disparity in growth will raise the median age from 35.3 to 39.0 and increase the percent of the population 65 and older from 12.4 percent to 19.7 percent.²

The retirement belt—the South and the West—will experience high growth rates in the elderly population (see Figure 3). In Nevada and Arizona elderly populations are projected to

climb by 264 percent and 255 percent, respectively. Overall, growth rates will be highest in the West, but the South will account for the highest portion—43.6 percent—of total elderly population growth.³

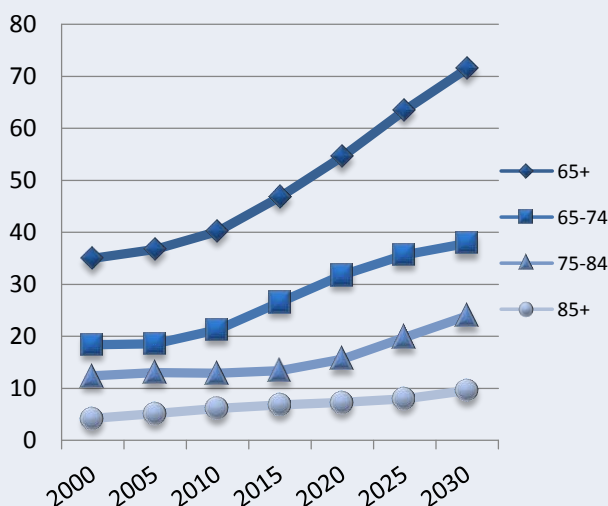
Minnesota Aging Compares Similarly to National Trends

Aging trends in Minnesota (shown in Figure 2) mirror national trends. The population of those 65 and older will double between 2000 and 2030, and the median age will rise from 35.4 to 39.0. At 18.9 percent, the percent of those over 65 in 2030 in Minnesota will be only slightly lower than the national average. Populations of the oldest of the old in Minnesota—those over 85—will not grow quite as fast as the national average, but they will still nearly double.

Minnesota will Age Slower than Neighboring States

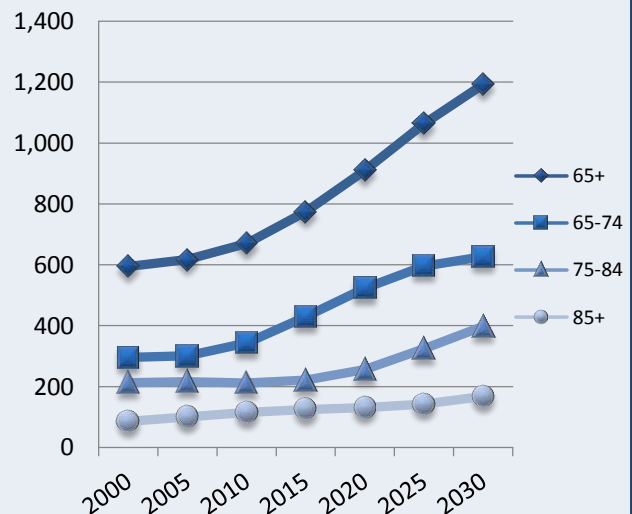
The Census Bureau projects Minnesota will age slower than its neighbors (see Figure 4). The median age will rise in Minnesota by 10 percent between 2000 and 2030; 15 percent in Iowa; 19 percent in North Dakota; 17 percent

Figure 1: U.S. Elderly Population Projections, 2000-2030 (in millions)



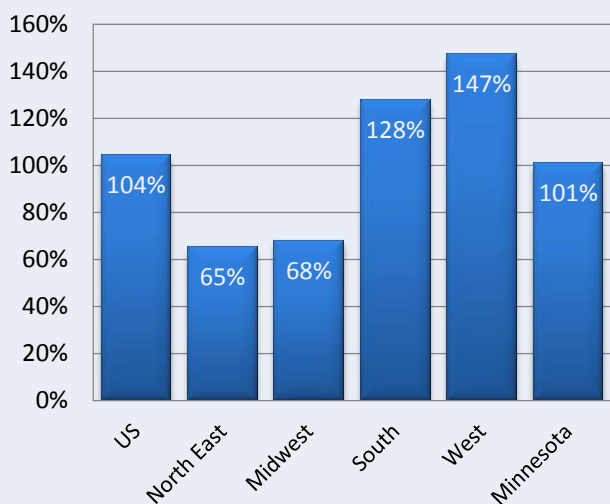
Source: U.S. Census Bureau, Population Division, Interim State Population Projections, 2005.

Figure 2: Minnesota Elderly Population Projections, 2000-2030 (in thousands)



Source: U.S. Census Bureau, Population Division, Interim State Population Projections, 2005.

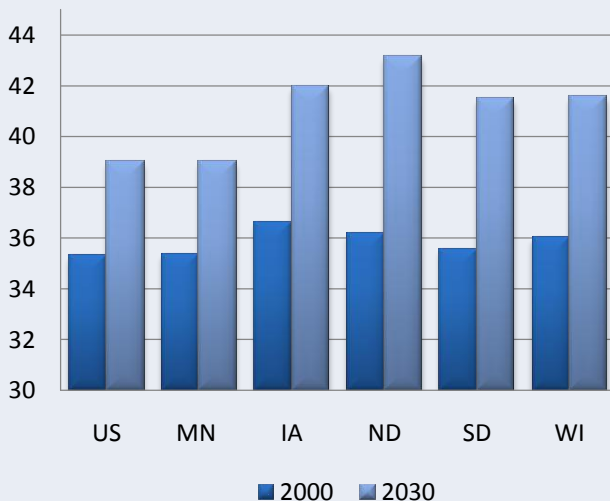
Figure 3: Projected Elderly Population Growth, 2000 to 2030



Source: U.S. Census Bureau, Population Division, Interim State Population Projections, 2005

in South Dakota; and 15 percent in Wisconsin. Minnesota will age slower, despite the fact that Minnesota's elderly population will grow much faster than each of its neighbors, because population growth in younger age groups will help offset the higher growth of its elderly population. Neighboring states actually experience population declines in younger age

Figure 4: Median Age, 2000 and 2030



Source: U.S. Census Bureau, Population Division, Interim State Population Projections, 2005.

groups. In fact, between 2000 and 2030, two age brackets—18 to 24 and 25 to 44—will shrink in each neighboring state.

Because Minnesota's elderly population will grow faster than its neighbors, demand for LTC services will also grow faster, which will put more pressure on Minnesota's LTC infrastructure to grow and to adapt.

The Ratio of Working-Age Adults to Retirees Declines

High elderly population growth rates do not create problems on their own; it's *disproportionately* high growth rates that create problems. Taxpayers, by way of Medicaid and Medicare, pay most LTC bills. More elderly without proportionately more non-elderly workers paying taxes, means the public burden of LTC will be concentrated on fewer and fewer workers as more and more boomers retire. Consequently, the main challenge to financing LTC is a shortage of taxpaying workers relative to the tax-subsidized elderly population.

The national worker-to-retiree ratio, estimated at 4.98 working-age adults per retiree in 2000, is projected to decline sharply to 2.89 working-age adults by 2030.⁴ Table 1 shows that every state will see its ratio decline, with states in the South and the West experiencing the sharpest declines.

Minnesota will do slightly better than average, moving from the 20th best ratio to the 16th best over the 30-year period. Minnesota's ratio in 2030—3.02—will be a good deal higher than neighboring states, which range from 2.14 in North Dakota to 2.65 in Wisconsin.

Labor Participation Rates Dropping

Falling worker-to-retiree ratios will contribute to a decline in the adult labor force participation rate, declining from 67.2 percent in 2000 to 60.5 percent in 2030.⁵ Aging, however, may not be the only factor behind

falling labor participation rates. U.S. labor participation rates among men and women aged 25 to 54 dropped between 1990 and 2000, suggesting other factors, beyond aging, might cause the workforce to shrink.⁶

National labor participation rates for men aged 25 to 54 declined from 91.4 percent in 1990 to 85.6 percent in 2000 (see Figure 5). Minnesota rates for men also declined, but remain at a much higher 91.3 percent, the second highest in the country. Likewise, national labor participation rates for women aged 25 to 54 dropped, but in Minnesota the rate increased, resulting in a Minnesota rate almost 10 percentage points higher—83.0 percent versus 73.5 percent—than the national rate (see Figure 6).

The Minnesota Department of Planning suspects more men claiming disability is responsible for much of the declining labor force participation rate.⁷

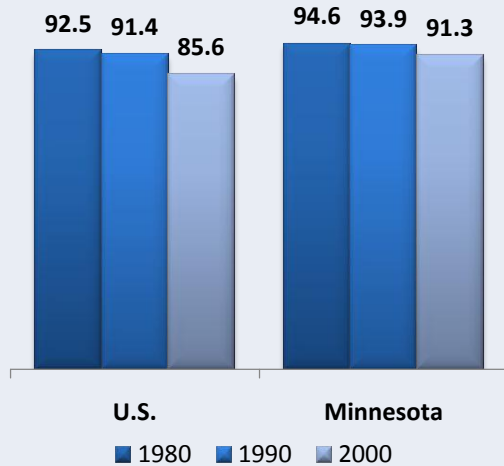
On the other hand, more people over age 65 are staying in the workforce, helping to moderate workforce declines. Between 1990 and 2000 the rate of men aged 65 to 69 in the workforce increased from 27.9 percent to 30.2 percent nationally, and Minnesota experienced a greater increase, rising from 28.7 percent to 33.2 percent. Many more women aged 65 to 69 also stayed in the labor force, increasing from 16.9 percent to 19.9 percent, nationally, and 18.2 percent to 24.0 percent in Minnesota.

Even more elderly are likely to work in the future. A Merrill Lynch survey found “baby boomers expect to spend a significant portion of their retirement working.” 71 percent of adults in the study say they will work in retirement and the two most important reasons boomers want to stay working are to keep mentally active and to keep physically active.⁸ Making money came in third. The study also found that those who work part-time enjoy retirement more than those who work full time or not at all.

Table 1: Worker-to-Retiree Ratio, 2000 and 2030

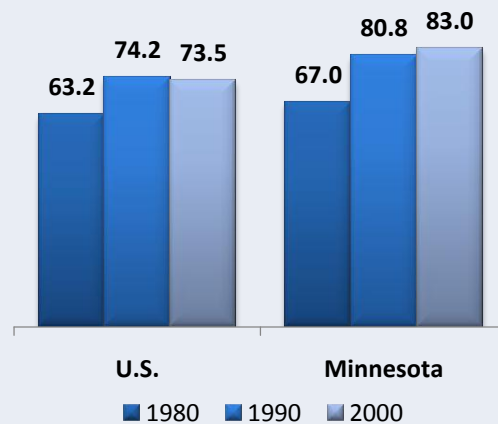
	2000 Ratio	State Rank	2030 Ratio	State Rank	30 yr. Decline
North East	4.50		2.70		-40.0%
Connecticut	4.45	41	2.61	36	-41.5%
Maine	4.31	44	2.09	48	-51.5%
Massachusetts	4.64	34	2.74	30	-41.0%
New Hampshire	5.26	16	2.66	31	-49.4%
New Jersey	4.68	33	2.89	21	-38.3%
New York	4.84	28	2.87	24	-40.7%
Pennsylvania	3.88	50	2.47	39	-36.3%
Rhode Island	4.25	45	2.65	32	-37.6%
Vermont	4.95	26	2.29	43	-53.7%
Midwest	4.78		2.89		-39.5%
Illinois	5.12	19	3.22	10	-37.1%
Indiana	4.99	25	3.15	13	-36.9%
Iowa	4.03	49	2.46	40	-39.0%
Kansas	4.55	39	2.76	27	-39.2%
Michigan	5.02	24	2.97	18	-40.9%
Minnesota	5.11	20	3.02	16	-40.9%
Missouri	4.52	40	2.79	25	-38.2%
Nebraska	4.43	42	2.63	34	-40.7%
North Dakota	4.09	47	2.14	46	-47.8%
Ohio	4.61	36	2.78	26	-39.7%
South Dakota	4.11	46	2.27	45	-44.8%
Wisconsin	4.69	32	2.65	33	-43.5%
South	5.00		2.84		-43.1%
Alabama	4.73	30	2.62	35	-44.6%
Arkansas	4.33	43	2.74	29	-36.6%
Delaware	4.79	29	2.34	42	-51.2%
D.C.	5.54	11	4.71	1	-14.9%
Florida	3.39	51	1.95	51	-42.6%
Georgia	6.66	4	3.65	5	-45.2%
Kentucky	5.04	22	2.90	20	-42.3%
Louisiana	5.29	14	2.87	23	-45.7%
Maryland	5.57	10	3.29	7	-40.9%
Mississippi	5.02	23	2.75	28	-45.2%
North Carolina	5.28	15	3.21	12	-39.2%
Oklahoma	4.61	37	2.87	22	-37.7%
South Carolina	5.19	17	2.53	37	-51.2%
Tennessee	5.10	21	2.94	19	-42.3%
Texas	6.22	5	3.69	4	-40.7%
Virginia	5.74	8	3.07	15	-46.5%
West Virginia	4.08	48	2.27	44	-44.3%
West	5.67		3.09		-45.4%
Alaska	11.22	1	3.86	3	-65.6%
Arizona	4.64	35	2.42	41	-47.8%
California	5.85	6	3.27	8	-44.1%
Colorado	6.69	3	3.53	6	-47.3%
Hawaii	4.70	31	2.49	38	-47.1%
Idaho	5.34	12	3.11	14	-41.8%
Montana	4.56	38	2.10	47	-54.0%
Nevada	5.79	7	3.02	17	-47.8%
New Mexico	5.17	18	1.96	50	-62.1%
Oregon	4.88	27	3.21	11	-34.1%
Utah	6.96	2	4.27	2	-38.7%
Washington	5.62	9	3.26	9	-42.0%
Wyoming	5.33	13	2.05	49	-61.5%
United States	4.98		2.89		-41.9%
Source: Author calculations derived from U.S. Census Bureau, Population Division, Interim State Population Projections, 2005.					

Figure 5: Labor Force Participation Rates for Men Aged 25-54 in the U.S. and in Minnesota



Source: Martha McMurry, *Minnesota Labor Force Trends: 1990-2000*, Minnesota State Demographic Center, December 2002.

Figure 6: Labor Force Participation Rates for Women Aged 25-54 in the U.S. and in Minnesota



Source: Martha McMurry, *Minnesota Labor Force Trends: 1990-2000*, Minnesota State Demographic Center, December 2002.

Though more elderly might work, many who want to work may choose not to work because current policies often discourage the elderly from working. For example, many elderly might like to continue working their present job in a diminished role at a lower salary. But U.S. pension law requires companies to calculate pensions based on the last five years of earnings and, therefore, working at a lower salary will lower their pension.

Higher Growth Rates will Make the Burden of LTC More Proportional

Some worry that uneven elderly population growth might result in some states shouldering a disproportionate share of America's LTC costs, suggesting that the current heavy reliance on state government should be reconsidered.

But the burden is already disproportionate. Table 1 shows fewer workers per retiree currently live in the Northeast and the Midwest, meaning the average Midwestern and Northeastern worker must pay a higher portion of each retiree's LTC bill. Higher elderly growth rates in the South and the West will make the burden of LTC more proportional by

creating a more equal distribution of worker-to-retirees across states.

However, a state's share of the LTC burden rests on many other factors beyond raw population numbers. Some states get only 50 percent of Medicaid costs reimbursed from the federal government while others can get up to 80 percent reimbursed. Moreover, some states provide more Medicaid LTC benefits than others and some states have lower rates of LTC utilization. Therefore, proportionality may still be a problem in the future, but it will be caused more by differing financing and eligibility policies across states than by uneven populations.

Despite a more proportionate population, Minnesota might still be shouldering a disproportionate future share of LTC costs. Minnesota gets reimbursed only 50 percent of Medicaid costs and has one of the highest nursing home utilization rates.

Retirees Moving to the South Do Not Appear Correlated with More LTC Needs

Intuition might suggest that states with large numbers of retirees should carry a much larger

share of the LTC burden. However, the three states with the highest net migration rate for 65- to 74-year olds—Nevada, Arizona, and Florida—also have some of the lowest rates of aged Medicaid beneficiaries.⁹ Nevada has the second lowest number of aged Medicaid beneficiaries per 1,000 people, Arizona has the third lowest, and Florida has the 20th lowest.¹⁰ All three states also have among the lowest nursing home utilization rates for those aged 85 and over; second lowest in Arizona, fifth lowest in Florida, and sixth lowest in Nevada.¹¹

Frequently those needing LTC move home to be near their children or other informal care givers, a fact that can help explain why retiree states do not have more LTC burdens. Southern and Western states accrue huge benefits from healthy taxpaying retirees who end up moving home when they become tax burdens.

Census data suggest that significant numbers of Minnesotans leave for retirement but move back for LTC. Between 1995 and 2000, 20.2 percent of Minnesotans aged 65 to 74 left the state for warmer climates.¹² Yet for those 85 and over, the migration flow resulted in a net

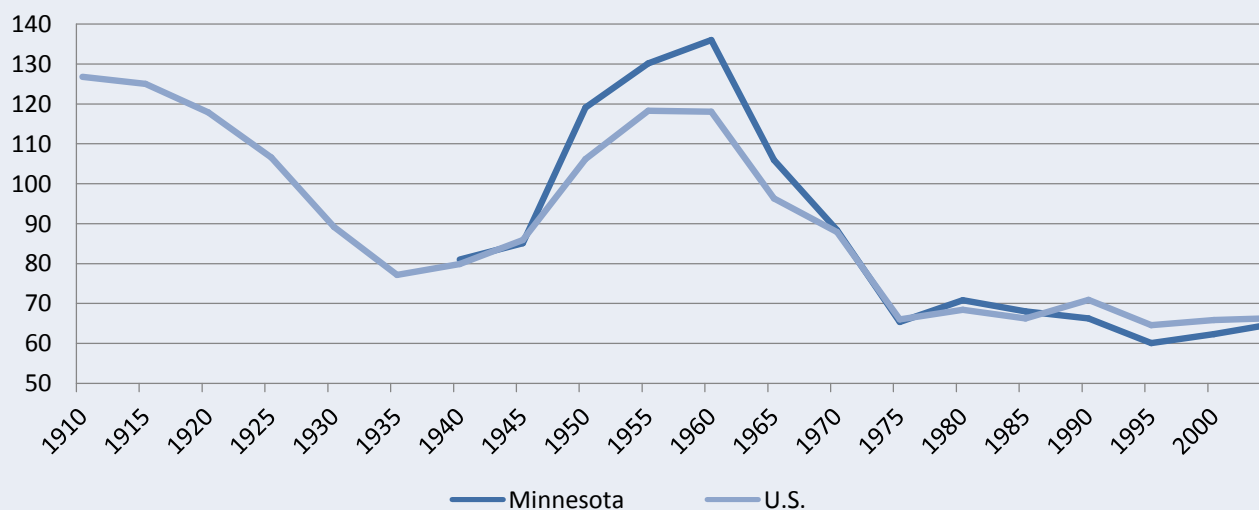
gain of 9.4 percent. A similar pattern plays out in Vermont, Rhode Island, Connecticut, Maryland, Kansas, Wyoming, Colorado, and Washington, and the reverse is true in Florida, Alabama, Mississippi, and Arkansas.

Even if Minnesotans do not move back for LTC, those Minnesotans financially able to retire to other states take their wealth with them and leave behind an elderly population less able to afford LTC on their own.

Fertility Rates Remain Very Low

High fertility rates in the 1940s and 1950s coupled with very low fertility rates since the late 1960s created today's disproportionate elderly population growth. Indeed, if it were not for the dramatic decline in fertility rates over the 1960s and '70s shown in Figure 7—which fell from a high of 122.7 live births per 1,000 women age 15 to 44 in 1957 to 65.0 in 1976—we might have enough Generation X workers to cover the costs of the boomer generation.¹³ The situation might also be different if fertility rates had rebounded, but fertility rates are no higher today than they were in the mid 1970s.

Figure 7: Fertility Rate, Live Births per 1,000 Women Aged 15-44 Years, 1910 - 2004



Source: National Center for Health Statistics, *Vital Statistics of the United States, 2001, Vol. 1, Natality*; Minnesota Department of Health, 2004 *Minnesota Health Statistics Annual Summary*, November 2005.

Today, the average U.S. family with a child under eighteen has 1.86 children.¹⁴ This is not even enough to replace his or her parents, let alone those adults who never have children.

In Minnesota, fertility rates in the boomer years swelled higher than the national average, but in the late 1980s, Minnesota's rate dipped below the national average.¹⁵ Minnesota's birth rate is now catching up with the national average.

Fewer Widows

One of the few demographic trends that will mitigate future LTC costs is the declining number of widows because of the often central role spouses play as live-in care providers.

A number of studies show that having a spouse can dramatically reduce the risk of needing formal LTC services. One study estimates that living alone can multiply the risk of nursing home admissions 1.6 times.¹⁶ Another study found that having a living spouse can decrease the length of nursing home stays by four months for men and three months for women.¹⁷ Further, according to the 1994 National Long-Term Care Survey, elderly widows and widowers use LTC at much higher rates than average: 26.2 percent versus 16.7 percent for all elderly.¹⁸

The percent of elderly widows dropped

significantly in the 1990s and is projected to continue dropping through to 2030. Nationally, the rate of elderly widowed women dropped from 49.4 percent to 45.3 percent between 1990 and 2000.¹⁹ For Minnesota the rate declined by even more from 48.6 to 44.1 percent.²⁰

Not nearly as many elderly men find themselves widowed. In 2000, widowers accounted for only 13.9 percent of elderly men nationally and 12.7 percent in Minnesota.

The public savings from fewer widows can be substantial. By a crude estimate, a 9 percent drop in the rate of widowed elderly women in Minnesota between 1990 and 2000 resulted in a \$46 million savings in 2000.²¹ Based on projections in Table 2, the rate may drop another 24 percent between 2010 and 2030, resulting in even more savings.

This trend is tightly linked to the decreasing disparity in life expectancies between men and women. And as long as men continue catching up, there will continue to be fewer widowed women, and thus fewer women needing formal LTC services.²²

More Elderly will have Never Married

The elderly never-married population will increase in the future and add to the public LTC burden.²³ Like widows and widowers, those

Table 2: Projected Marital Status of the U.S. Elderly Population

	2010	2030	2050	2070
Males				
% Married	73.0%	68.9%	65.9%	65.5%
% Widowed	14.9%	13.0%	13.6%	12.7%
% Divorced	7.3%	9.5%	8.5%	8.5%
% Never Married	4.8%	8.6%	11.9%	13.3%
Females				
% Married	41.4%	44.8%	41.9%	43.5%
% Widowed	45.1%	34.2%	35.8%	33.7%
% Divorced	9.1%	14.9%	13.8%	13.4%
% Never Married	4.4%	6.1%	8.5%	9.4%

Source: David M. Cutler and Louise Sheiner, Demographics and Medical Care Spending: Standard and Non-Standard Effects, Burch Working Paper No. B98-3, Table 15, November 1998.

who never marry lack live-in care, and so they too use LTC services at higher rates.²⁴ Further, those never married are less financially prepared to privately finance LTC. In the 1999 National Nursing Home Survey, 69 percent of those single or never married relied on Medicaid as the primary source of payment, versus 57 percent for widows and 49 percent for married individuals.²⁵ Those never married also stay in nursing homes almost a year longer than average.²⁶ The added public cost of more elderly never marrying will be substantial.

Immigration

Barely heard in the heated national debate over immigration, some immigration supporters now argue that increasing inflows of immigrants can ease the country's LTC burden.

Future LTC costs might indeed be mitigated by a consistent flow of immigrants to the United States. Annual immigration—the legal kind—has remained fairly constant since 1992, the year the Immigration Act of 1990 took effect, at an average of 837,000 people annually.²⁷ That number bumped up some in recent years and might rise even more if Congress and the president can agree on immigration reform.

Immigration can help mitigate the LTC burden in a number of ways. Immigrants are almost universally hard-working; nationally, much higher rates of foreign-born men (81.3 percent) participated in the 2005 labor force than native-born men (71.9 percent).²⁸ This labor infusion helps slow declining ratios of workers to retirees. Immigrant fertility rates also are higher, which will add to future working-age populations. Moreover, immigrants are more willing than native-born workers to take difficult and low-paying jobs in LTC facilities.²⁹

Already, the foreign-born population in Minnesota contributes a sizable and increasing share of new-born children. During the 1990s, the proportion of births to foreign-born mothers in Minnesota increased from 5.4 percent to 13.4

percent, thanks to a much higher fertility rate—108.3 per 1,000 women aged 15 to 44 versus 58.4 for U.S.-born mothers.³⁰

Many argue these new immigrants become a drain on public resources because so many come with low-skill sets and few assets. Some researchers contend a minority of immigrants, due to transplanting amongst the urban poor, assimilate to the pathologies of the native poor and become trapped in poverty.³¹ However, even these pessimistic researchers admit that a majority of today's immigrants assimilate quite well.³² And there is much optimistic research showing that second generation immigrants of today assimilate even faster than past waves of immigrants, refuting pessimistic claims that certain segments of immigrants are destined to languish in poverty.³³

Demographics Underscore the Importance of a Strong Economy and Strong Families

According to the demographics surveyed above, Minnesota can expect many more elderly in need of LTC and at the same time fewer resources available to pay for it. The future need for LTC in Minnesota will rise in step with a doubling elderly population, about average for the nation, but much bigger than its Midwest neighbors. The demographics also suggest that Minnesota might not gain any reprieve from elderly men and women retiring to the South and West, since many end up moving back. This appears especially true since those who move away tend to be healthier and more able to afford their own LTC.

Demographics also speak to the resources available to pay for LTC and those resources are dwindling. Most troubling, the number of taxpaying workers per retiree, both nationally and in Minnesota, will steadily diminish, meaning public coffers will find it increasingly difficult to fund the public cost of LTC. National population projections estimate there will only be 2.89 taxpaying workers for each retiree by 2030, a scenario that could be made worse by declines in labor participation rates

among 25 to 54 year olds. Minnesota's public resources won't dwindle quite as much as other states, thanks to higher labor participation rates and higher growth in younger populations, but only marginally so.

Families are the most important resource for LTC at the end of life. Having a living spouse can decrease the length of nursing home stays by four months and having living children can decrease nursing home stays by three months.³⁴ But compared to their forebears, boomers marry less and raise fewer children. Fortunately, the number of widows will continue to decline as men's life expectancies catch up to their better halves, helping offset a portion of the family resources lost to less marriage and fewer children.

Demographic trends and projections reveal a number of cultural and economic issues critical to understanding and in some cases combating the future cost of LTC, including:

- Can the LTC market—possibly the most highly regulated market of all—meet future spikes in demand for LTC services?
- Do lower labor participation rates among 25 to 54 year olds reflect a decline in America's work ethic, and if so, what can be done to reinforce it?
- Should the elderly be encouraged to work into retirement?
- If rising numbers of people over the age of 65 are able to work, does that mean that declining numbers should be eligible for retirement benefits?
- Does the present disproportionate population distribution, and resulting disproportionate share of LTC costs among states, suggest problems with the state and federal funding roles?
- Do Minnesotans truly move south for retirement and back home for LTC? If so, do they move simply for the warmth or do Minnesota's high taxes encourage movement as well? And do they primarily move back for LTC, to be near

family or to qualify for public LTC benefits?

- Why have national and Minnesota fertility rates remained so low? Can and should anything be done to influence very personal decisions to have children?
- If the declining rate of widows is due to the decreasing disparity in life expectancies between men and women, is enough being done to promote health among men so that the gap narrows even more?
- Can anything be done to at least halt the rising proportions of those who never marry?
- Would allowing more immigration be a net gain or a net drain to public resources?

The above demographics and the issues they beg and reveal underscore two central lessons. First, a strong economy, by keeping more people in the workforce and by propelling higher wages, will be indispensable to financing tomorrow's LTC bills. Policies, therefore, that make Minnesota a more attractive place to live, work, and build a business will mean more resources available to fund LTC.

Second, if it appears too late for larger families to help reduce problems, consider that a child born today will turn 20 when the first boomers begin turning 80, right around the time they start needing LTC in larger numbers. Today's newborns, in other words, will be entering the workforce and paying taxes. They'll also be old enough to help care for grandparents.

A strong economy and larger families will both help to fulfill the LTC needs of boomers. But what will those needs be? We know that doubling elderly populations will raise the need, but that is not the whole story. Future LTC needs will largely depend on the health and well-being of boomers as they age, issues the following section of this report addresses in more detail.

The Future Health Status of Aging Baby Boomers

The health status of aging baby boomers will have profound implications on LTC needs, but overall better health will not necessarily mean less need or less costly LTC. While better health is clearly less expensive for the nonelderly, this does not necessarily hold true for the elderly. Medical advances that lower risks for certain health problems extend life, and any added months or years create new opportunities to develop other, possibly more costly health problems. In fact, recent studies suggest that better health in old age, instead of lowering costs, actually shifts costs from acute care (doctor visits and limited hospital stays) to LTC.

Certain diseases lead to a higher share of LTC costs than others and, therefore, must be understood more carefully. Table 3 shows the results of a study that tracked Veterans Affairs patients’—a very large sample of the nation’s elderly LTC users—LTC costs associated with specific chronic conditions.³⁵ Of the 29

chronic conditions tracked by the study, dementia-related diseases and circulatory system diseases accounted for the largest portion of LTC costs.

Self-Reported Health Status

Two surveys—the National Health Interview Survey (NHIS) and the Behavioral Risk Factor Surveillance System (BRFSS)—periodically track a number of U.S. health trends. The NHIS tracks nationwide trends and the BRFSS tracks trends at the state, county, and city levels. Each survey regularly asks respondents almost identical survey questions about whether they rate their general health as excellent, very good, good, fair, or poor.

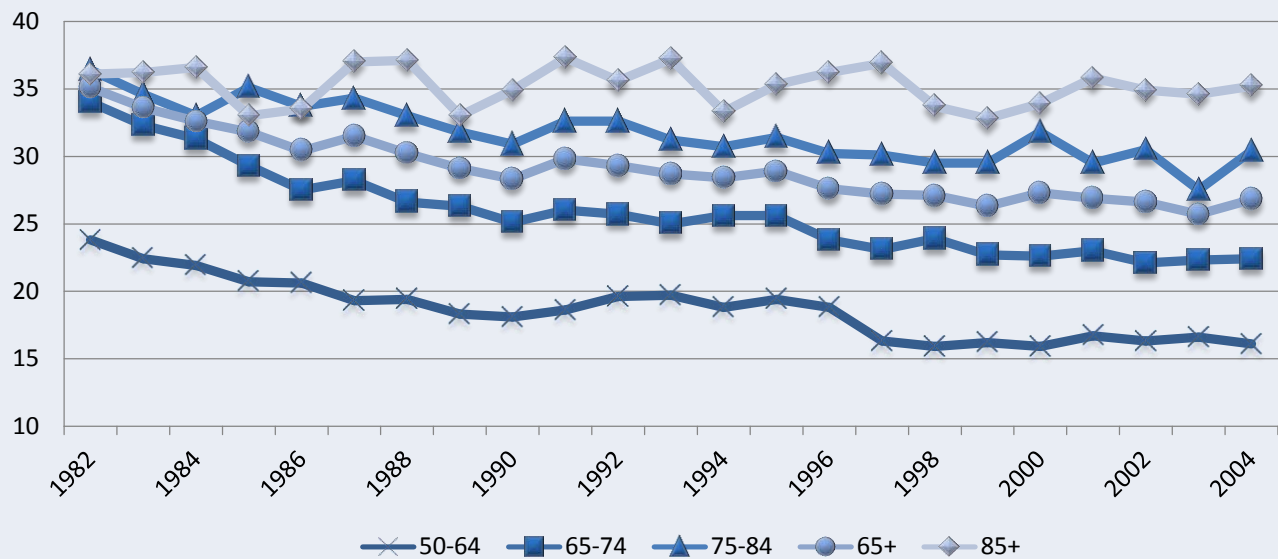
The elderly and baby boomers both report better health on the NHIS survey. Between 1982 and 2004, Figure 8 shows consistently lower rates of people over 50 years old self-assessing their health as poor or fair in the NHIS survey: 32.4 percent less for those 50 to 64; 34.1 percent less for those 65 to 74; 16.5 percent less for those 75 to 84; and 2.5 percent less for those 85 and over.³⁶

Table 3: Mean and Total Long-Term Care Costs Among Veterans

65 to 79 Years				80 Years and Over			
Chronic Condition	Mean LTC Cost	Total LTC Costs	Percent of Total LTC Costs	Chronic Condition	Mean LTC Cost	Total LTC Costs	Percent of Total LTC Costs
Dementia	5,785	98,865,650	11.23%	Dementia	6,934	79,304,158	15.66%
Cancer	808	95,789,385	10.88%	Alzheimer’s disease	10,522	58,239,270	11.50%
Congestive heart failure	1,055	77,311,455	8.78%	Congestive heart failure	2,123	53,686,424	10.60%
Psychoses	1,921	72,448,594	8.23%	Cancer	1,330	42,215,643	8.33%
Renal failure	2,042	71,612,940	8.13%	Renal failure	3,147	36,826,194	7.27%
Alzheimer’s disease	9,006	64,464,948	7.32%	Psychoses	3,949	30,683,730	6.06%
Cerebrovascular disease/stroke	1,642	52,701,632	5.98%	Cerebrovascular disease/stroke	2,620	23,454,240	4.63%
Peripheral vascular disease	705	38,041,095	4.32%	Parkinson’s disease	3,879	21,691,368	4.28%
Chronic obstructive pulmonary disease	410	37,186,590	4.22%	Chronic obstructive pulmonary disease	1,135	21,128,025	4.17%
Alcoholism	1,722	37,002,336	4.20%	Peripheral vascular disease	1,505	20,425,860	4.03%

Source: Author calculations derived from Wei Yu, et al., “The Relationships Among Age, Chronic Conditions, and Healthcare Costs,” *The American Journal of Managed Care*, Vol. 10, No. 12, December 2004.

Figure 8: Percent Reporting Poor or Fair Health, U.S., 1982-2004



Source: Centers for Disease Control and Prevention, National Health Interview Survey.

Overall, Minnesotans report lower rates of poor or fair health than any other state in the most recent BRFSS surveys.³⁷ However, 50- to 64-year-old Minnesotans began reporting higher rates of poor to fair health in 2000-2002 (see Figure 9). But even with a slightly higher rate, that group still reported the second lowest rate (13.0 percent) in the country. Minnesotans also

reported the second lowest rate for those aged 65 to 74 (18.5 percent), but Minnesota's ranking dropped to 13 for those 75 and over.

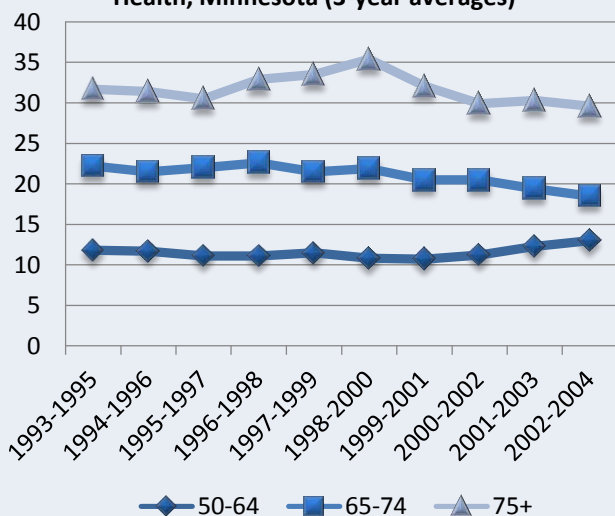
Three issues and inconsistencies stand out from the NHIS and BRFSS surveys. First, while the NHIS consistently reports healthy trends for those over 50, most states in the BRFSS survey report higher rates of poor to fair health for those 50 to 64.

Second, though NHIS and the BRFSS surveys show declines in the rate of people over 75 who report poor to fair health, they are slight and fall well within the survey's margin of error. Therefore, the self-reported health of the group most in need of LTC appears to be stagnating.

Third, reading the state-level data reveals a wide disparity in reported health status, with Southern states reporting significantly higher rates of poor to fair health in the boomer bracket.

Take note that all three issues suggest the health of boomers and the elderly may not be trending as positive as NHIS surveys indicate.

Figure 9: Percent Reporting Poor or Fair Health, Minnesota (3-year averages)



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System.

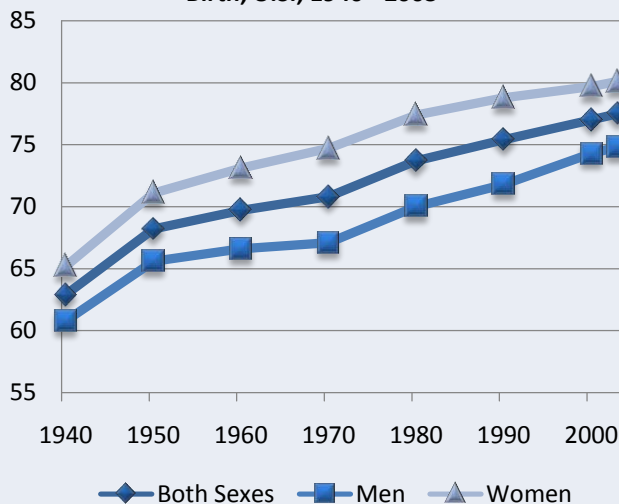
Life Expectancies Rising

Life expectancies continue to rise, reflecting an overall improvement in the health of Americans. National life expectancies rose from 68.2 years in 1950 to 77.5 years in 2003, and the life expectancy of those who reach 65 years rose even more dramatically on a proportionate basis, from 13.9 additional years of life in 1950 to 18.4 additional years in 2003, an increase of 32 percent.³⁸

Minnesota life expectancy trends mirror national trends. Minnesotans, however, can expect longer lives, and, in fact, Minnesotans had the second longest life expectancy—79.1 years—in 2000.³⁹

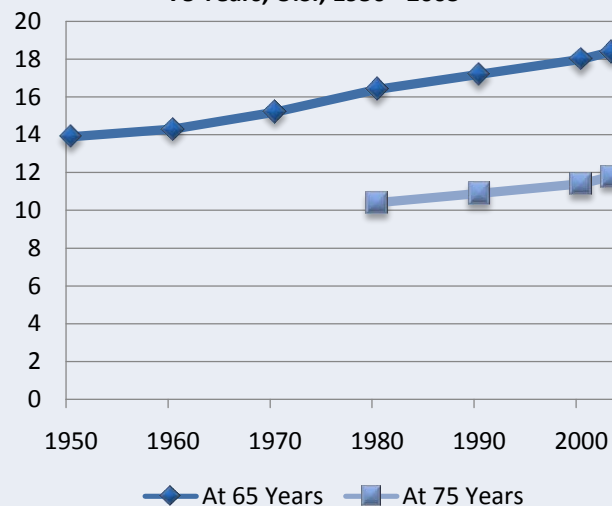
The discrepancy between the life expectancies of men and women continues to diminish, which, as discussed earlier, directly affects the provision of informal care giving; i.e., more men living long enough to care for their wives. Between 1980 and 2000, the gap narrowed by two years in the U.S.—from 7.4 to 5.4 years—and, in Minnesota, the gap narrowed by 2.5 years—from 7.3 to 4.8.⁴⁰

Figure 10: Life Expectancy at Birth, U.S., 1940 - 2003



Source: Donna Hoyert, et al., *Deaths: Final Data for 2003*, National Vital Statistics Reports, Vol. 54, No. 13, April 19, 2006).

Figure 11: Life Expectancy at 65 Years and at 75 Years, U.S., 1950 - 2003



Source: Donna Hoyert, et al., *Deaths: Final Data for 2003*, National Vital Statistics Reports, Vol. 54, No. 13, April 19, 2006.

Gerontologists debate whether the human life span is limited.⁴¹ Some argue there is no observable limit since life expectancies in the developed world have continually risen by an average of 2.5 years per decade since 1840 and at this point there is no reason to believe that trend will stop. Others, arguing from evolutionary theory, claim that humans have a “biological warranty period”—a statistical limit on life spans regardless of medical advances—because the body stops maintaining itself once the reproductive phase of life ends. They argue recent increases in life expectancies came from solving some relatively simple health problems and that future increases will not come so easily or cheaply.

But do rising life expectancies represent more years walking on the beach or more years nodding off in a nursing home lobby? Advances in medical technology have the potential to keep someone alive in a diminished state, which appeared to be more often the case in the 1970s. But in the last 25 years, studies show gains in life expectancy to more likely reflect additional healthy years of living.⁴²

Death Rates Dropping

Along with rising life expectancies, death rates continue to drop year after year. Mostly because of improvements in treating heart and cerebrovascular diseases, between 1950 and 2003 death rates dropped 45 percent among 65- to 74-year-olds; 41 percent among 75- to 84-year-olds; and 28 percent for those 85 and over.⁴³ Though cancer-related death rates are still higher than in 1950, they began declining in 1994 for both the 65 to 74 and the 75 to 84 age groups.

Some elderly death rates, however, are not dropping. Elderly death rates from lung cancer and chronic lower respiratory diseases—two conditions that result in significant LTC costs—steadily rose until 2000 and it remains unclear whether rates have leveled off. Death rates from Alzheimer's disease and hypertension are also rising among elderly populations.⁴⁴

Minnesota's overall age-adjusted death rate—713 per 100,000—trails only Hawaii for the lowest rate in the U.S.⁴⁵ Minnesota's lower death rate can mostly be attributed to having the nation's lowest rate of heart disease deaths,

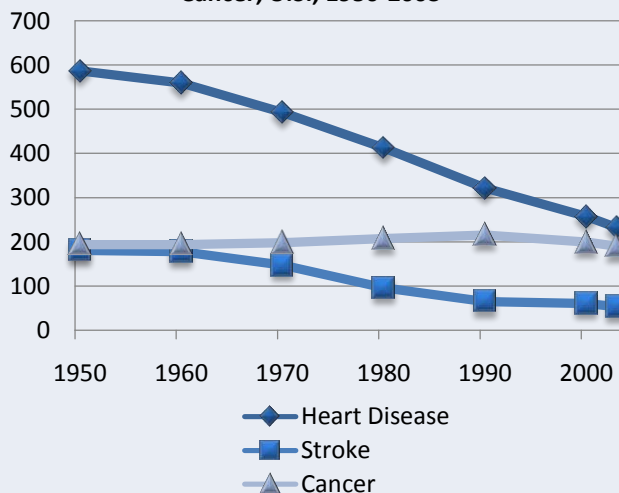
but Minnesota death rates are also far lower on many other fronts, including HIV, influenza and pneumonia, lower respiratory disease, and liver disease.

The Prevalence of Alzheimer's Disease May Rise Even Faster than the Elderly Population

Alzheimer's disease, senile dementia, and other mental disorders deserve special attention because together they result in substantial LTC costs. Combined, these conditions represent the primary diagnosis for 26.6 percent of all nursing home residents.⁴⁶ In the veterans study referenced earlier, Alzheimer's, dementia, and psychoses accounted for 29.1 percent of total elderly LTC costs.⁴⁷ Further, consider the number of new assisted-living facilities entirely devoted to dementia-related conditions.

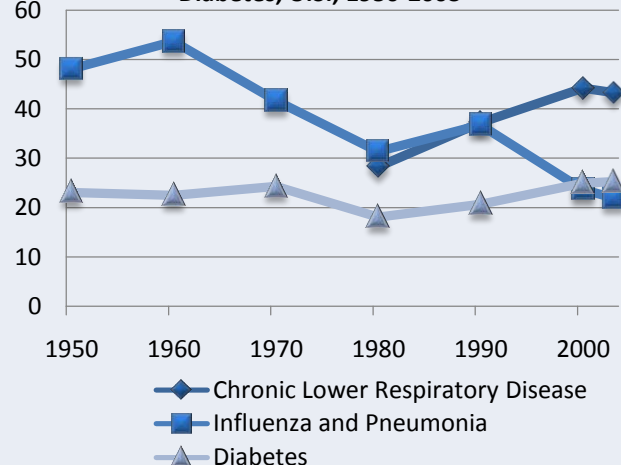
Most with dementia, however, live at home and receive care from family and friends. One study estimates the annual cost of informal dementia care at \$18,385 for such patients.⁴⁸ This estimate includes the value of caregivers' time (\$6,295), caregivers' lost income (\$10,709), and caregivers' out-of-pocket costs for purchasing formal care.

Figure 12: Age-Adjusted Deaths per 100,000 People Due to Heart Disease, Stroke, and Cancer, U.S., 1950-2003



Source: U.S. Department of Health and Human Services, *Health, United States, 2005*.

Figure 13: Age-Adjusted Deaths per 100,000 People Due to Chronic Lower Respiratory Disease, Influenza and Pneumonia, and Diabetes, U.S., 1950-2003



Source: U.S. Department of Health and Human Services, *Health, United States, 2005*.

Without medical breakthroughs, the prevalence of Alzheimer's and related conditions likely will quadruple by 2050.⁴⁹ Alzheimer's prevalence will rise faster than the elderly population because the rate of Alzheimer's increases exponentially with age, and more people will survive other diseases allowing them to live longer with Alzheimer's.

There is some cause for hope. Recent scientific discoveries of a gene associated with a higher risk of Alzheimer's, as well as certain experimental drugs, show promise in delaying the onset of Alzheimer's. Another study found the possibility of an upper bound to how high the Alzheimer's rate can climb, and so the rate of Alzheimer's may actually begin declining at age 93 for men and age 97 for women, rather than continuing to rise exponentially.⁵⁰ If true,

rising life expectancies will have less of an impact on the rate of Alzheimer's than present estimates project.

Despite hopeful developments, no solid breakthrough exists to either cure or prevent Alzheimer's. Diagnoses of Alzheimer's continue to increase.⁵¹ Therefore, we must assume Alzheimer's and other dementias will create even higher demand for LTC once boomers begin turning 75.

Higher Prevalence of Chronic Conditions among the Elderly

Recent surveys show upward ticks in the prevalence of many chronic conditions among the elderly. Table 4 shows hypertension, strokes, asthma, breast cancer, prostate cancer,

Table 4: Prevalence of Selected Chronic Conditions by Age: United States, 1997-2004

Condition	45-64 Years		65-74 Years		75-84 Years		85+ Years	
	1997-1998	2003-2004	1997-1998	2003-2004	1997-1998	2003-2004	1997-1998	2003-2004
All types of heart disease	13.4	12.5	27.8	27.3	36.0	36.1	40.7	39.0
Coronary heart disease	7.0	6.7	18.7	18.2	23.9	24.9	24.5	25.1
Hypertension	27.0	30.1	45.0	49.3	49.0	56.2	45.7	50.2
Stroke	2.3	2.4	6.7	7.1	9.7	10.6	10.5	14.8
Emphysema	2.1	1.9	5.3	5.0	5.4	5.6	3.8	4.8
Asthma	9.1	9.9	8.2	9.6	7.3	8.7	6.4	6.5
Hay fever	9.8	10.1	7.2	7.9	6.1	6.5	6.1	5.0
Sinusitis	19.2	17.0	16.3	15.3	13.6	14.0	12.3	9.8
Chronic bronchitis	5.5	4.9	7.0	6.2	6.2	6.3	4.8	4.3
Any cancer	7.2	7.9	17.0	18.3	20.8	22.8	20.2	24.1
Breast cancer	1.2	1.4	3.0	3.5	4.1	4.1	5.3	5.7
Cervical cancer	1.3	1.1	1.1	1.0	0.8	0.9	—	—
Prostate cancer	0.8	1.0	5.8	5.6	9.9	11.1	7.0	11.2
Colon/Rectal cancer	0.4	0.4	1.4	1.9	2.7	2.8	2.4	4.2
Uterine cancer	1.1	0.8	1.3	1.0	1.9	1.4	1.4*	1.5
Lung cancer	0.2	0.2	0.7	0.9	0.7	1.2	—	—
Melanoma	0.4	0.7	0.9	0.9	0.6	1.2	1.2*	1.3
Skin cancer	2.0	2.2	5.1	5.3	5.3	6.3	5.1	6.0
Diabetes	7.8	9.5	14.1	18.1	12.6	16.8	9.1	12.3
Ulcer	11.1	8.3	13.6	11.3	14.5	12.6	13.7	12.4
Kidney disease	1.8	1.7	2.8	3.2	3.5	4.1	5.5	6.5
Liver disease	1.6	2.0	1.4	1.3	1.0	1.6	1.0	1.3

* The data shown represents 1999-2000 data as 1997-1998 data was unavailable.

Source: Centers for Disease Control and Prevention, National Health Interview Survey.

colon/rectal cancer, lung cancer, melanoma, skin cancer, diabetes, kidney disease, and liver disease generally increased across the elderly population between 1997 and 2004.⁵²

Boomers also experienced increasing rates of many of the same chronic conditions, including hypertension, stroke, asthma, hay fever, breast cancer, prostate cancer, melanoma, skin cancer, diabetes, and liver disease. But, the rates of some chronic conditions that increased among the elderly—colon/rectal cancer, lung cancer, and kidney disease—stabilized or fell among boomers.

Higher rates of chronic disease do not necessarily mean diminished health. It might indicate advances in medical treatments that allow people to survive longer with chronic disease and provide more time for additional chronic disease to develop. This explains how declining stroke death rates and declining cancer incidence can coexist with rising prevalence of cancer and strokes. This reasoning fits best for the elderly (who have had more time to live with their disease), but not as well for the younger boomers. For boomers, who have spent less time with

chronic conditions, more prevalent chronic disease could indeed mean diminished health.

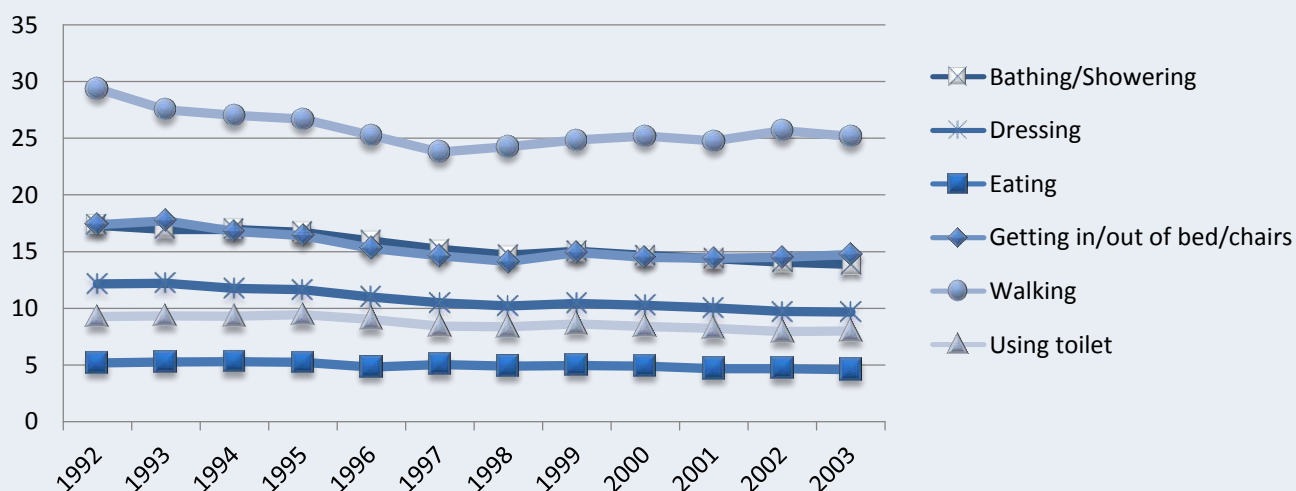
Higher disease prevalence suggests higher acute care costs. To the extent medical advances are responsible for higher disease prevalence, such advances add significant costs. More specifically, beyond the cost of the specific medical technology, the longer life may result in more trips to the doctor, pharmacy, and hospital for other health care needs.

Trends in chronic conditions send more mixed signals on LTC costs. More people with Alzheimer's disease, kidney disease, strokes, and lung cancer suggest higher LTC costs. On the other hand, lower rates of heart disease, chronic bronchitis, emphysema, and kidney disease among boomers should moderate LTC costs.

Disability Rates Dropping

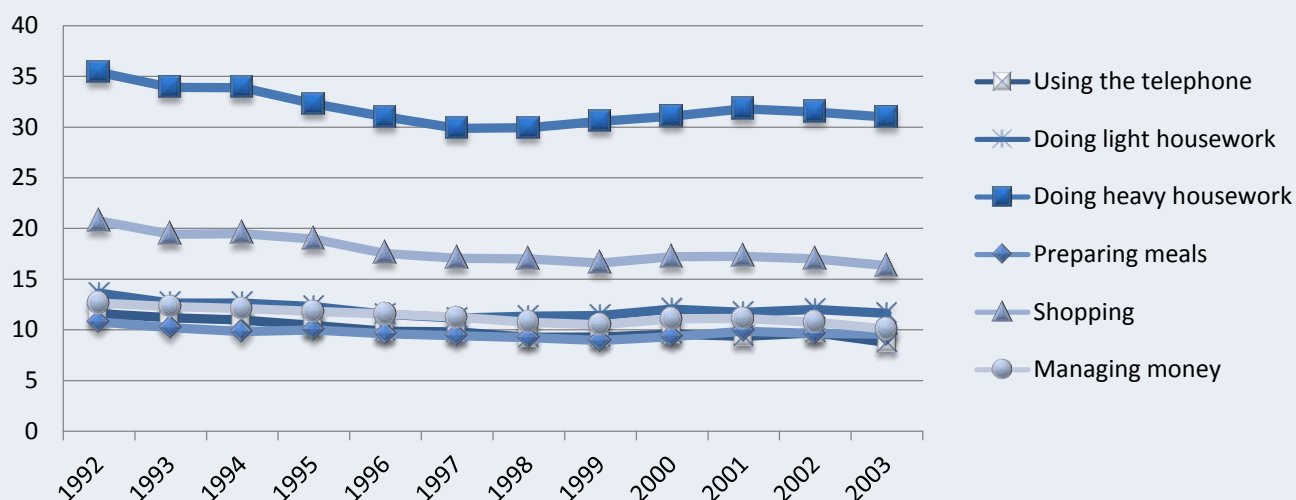
Most research on the health status of the elderly focuses on disability, as disability directly affects independence and the need for LTC. Disability measures usually rely on population

Figure 14: Percent of Elderly with Difficulty Performing Activities of Daily Living, U.S., 1992-2003



Source: Centers for Disease Control and Prevention, National Health Interview Survey.

Figure 15: Percent of Elderly with Difficulty Performing Instrumental Activities of Daily Living, U.S., 1992-2003



Source: Centers for Disease Control and Prevention, National Health Interview Survey.

surveys that ask people to report any physical or cognitive impairments they might have. The two measures most commonly used in surveys are activities of daily living (ADL), which is a measure of personal care abilities such as bathing and dressing; and instrumental activities of daily living (IADL), which is a measure of abilities necessary to maintain independence, such as money management and preparing meals. ADL is the more severe disability associated with needing LTC services.

Since the 1980s, most measures of disability among the elderly have declined, with the most pronounced decline taking place in the 1990s.⁵³ Likely contributors include improving medical technology, healthier behavior, increasing use of preventative measures, increasing use of aids, higher education levels, rising wealth, and less exposure to disease.⁵⁴ One review of the literature found average annual declines in the prevalence of any disability among older adults ranged from -1.55 percent to -0.92 percent in studies measuring trends in the 1980s and '90s.⁵⁵ Studies show that decreases in IADL disability account for most—80 percent according to one study—of the decline,

meaning there has been far less of a decline in the severe disabilities that require costlier LTC services.⁵⁶

In the 2000 Census, elderly women reported having two or more disabilities at higher rates than men—19.7 percent higher in Minnesota and 24.1 percent higher nationally—which is consistent with other studies showing elderly women become more severely disabled at higher rates than men.⁵⁷

Elderly Minnesotans report both lower disability rates and less severe disability on the 2000 Census. 19.1 percent of elderly Minnesotans reported having one disability and 17.7 percent reported having two or more disabilities, compared to a national average of 20.1 percent reporting one disability and 21.8 reporting two or more.⁵⁸

Disability Projections

Many studies predict an optimistic future, projecting declining disability and longer working lives, more active retirements, and less need for LTC services.⁵⁹ Disability is expected to decline mostly because of medical advances,

but also because boomers are better educated, wealthier, worked in less physically demanding careers, and take more preventative measures than previous generations.

One of the most optimistic studies foresees a 1.5 percent annual decline in elderly disability, assuming larger-scale adoption of preventative measures, wide dissemination of technology advances, and additional investments in biomedical research.⁶⁰ Under this scenario, working life could increase by five years or more and, on net, the actual number of disabled elderly could remain constant despite the rapid rise in the elderly population.

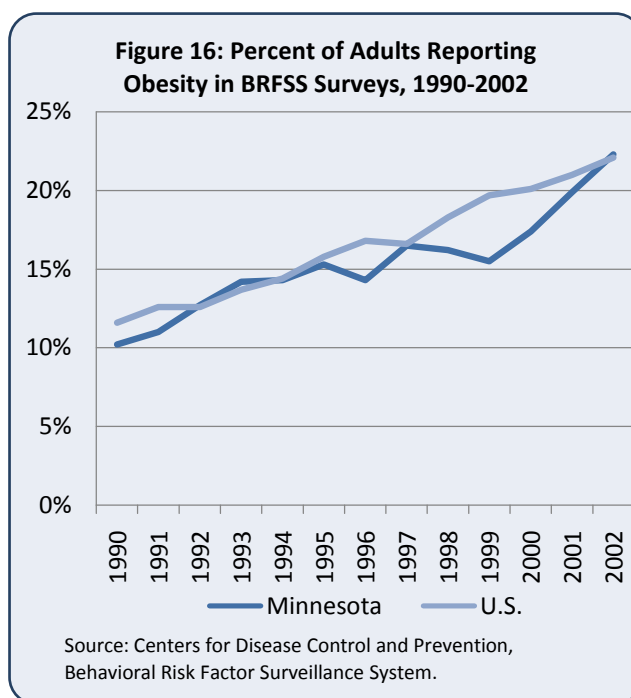
Lower overall costs, however, depend on lifestyle changes—more exercise and better nutrition—not technology, since, historically, new medical technologies have been linked to higher demand and use and, therefore, higher health insurance costs.

Some observers are less optimistic that disability rates will drop. They argue that rising obesity will lead to more disability, that the prevalence of debilitating dementia is on the rise, and that smoking, excessive drinking, and the lack of exercise remain all too common. Further, not every study finds declining disability over the past couple decades.

There are solid reasons to be optimistic that disability rates will decline, but there is no guarantee, especially in light of rising obesity rates, and even if disability does decline, the overall cost savings may be minimal if reductions rely too much on expensive technology.

Obesity Rates Rising

Slimming America's waistline would go a long way to soothing fears that disability rates might rise. Nonetheless, obesity rates continue to grow rapidly. In fact, the Centers for Disease Control and Prevention (CDC) now call it an epidemic. Between 1990 and 2002, BRFSS



surveys (shown in Figure 16) report the median state obesity rate for adults increased from 11.6 percent to 22.1 percent.⁶¹ For Minnesota the numbers were worse, rising from 10.2 percent to 22.3 percent.

Other measures peg national adult obesity rates at a much higher 30.4 percent.⁶² Men (35.5 percent) and women (42.1 percent) aged 55 to 64 weighed in with the highest rates of obesity, but every age group measured extremely high rates (see Figure 17).

Some worry that disability rates will increase once obese boomers start experiencing the disabling effects of obesity: diabetes, heart disease, hypertension, cancer, and arthritis.⁶³ If true, it will be costly.⁶⁴ One study, predicts the obese elderly will live just as long, but will spend \$39,000 more on health care, largely because they will live at least 40 percent more of their life with debilitating and often institutionalizing disabilities.⁶⁵

The health impact of obesity is already evident among boomers. As obesity rates have risen so has the prevalence of hypertension and diagnosed diabetes. The prevalence of hypertension among adults aged 40 to 59

increased from 27.0 percent in 1988 to 30.1 percent in 2000.⁶⁶ Between 1994 and 2004, the prevalence of diagnosed diabetes per 100 people aged 45 to 64 rose from 6.3 to 9.5.⁶⁷

Minnesota boomers experienced a more dramatic doubling of their diabetes rate, rising from 3.6 to 7.3.⁶⁸ But Minnesota's rate—third lowest rate among all adults and sixth lowest among adults aged 45 to 64—still reflects a far healthier population.

Obesity, however, is only one factor among many that will impact future disability rates. And with most other factors trending positive, many continue projecting declines in future disability rates.

Maybe the most important point made by the research is that the disability trend itself depends on choices we make today. If we forgo Kong-sized meal portions, if we get colonoscopies, if we regularly go for brisk walks, and if we keep investing in biomedical technology, disability rates will almost certainly decline. Fortunately, more and more elderly and near-elderly are already choosing to take steps—eating habits aside—that maintain good health and prevent or delay the onset of chronic diseases and disability. As the following pages show, retirees lead

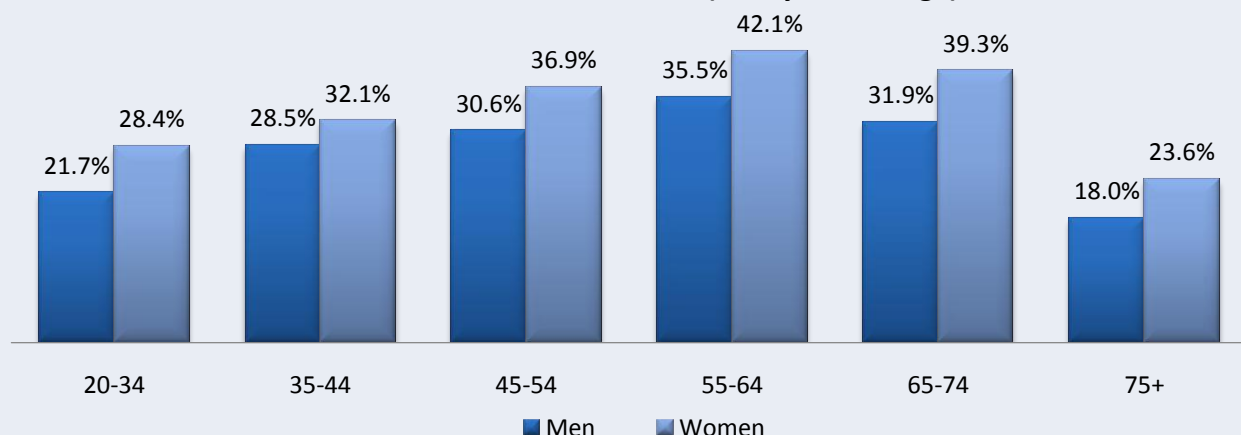
increasingly active lifestyles, exercise more, and take more preventative steps against illness.

Rising Numbers of Boomers and the Elderly Take Steps to Prevent Illness

Future cost control depends on the large-scale adoption of preventative measures. The costs associated with preventative measures pale in comparison to the lifetime costs of preventable chronic conditions like diabetes and cardiovascular diseases. Preventable illnesses account for about 70 percent of the total cost of illness in this country.⁶⁹ Indeed, the old saw about an ounce of prevention seriously underestimates the value that preventative steps—good nutrition, regular exercise, disease screening, vaccinations, and immunizations—can return to those who take them.

Are today's elderly and baby boomers taking the necessary steps to prevent debilitating and costly disease? Yes and no. When the prevention can be had through a doctor's visit or a drug, like cancer screening and cholesterol lowering drugs, the answer is mostly yes. But when prevention requires more day-to-day self-discipline, like diet and exercise, the results are mixed.

**Figure 17: Obesity Rates Among Men and Women
20 Years and Older, 1999-2002 (four-year average)**



Source: Centers for Disease Control and Prevention, National Health and Nutrition Examination Survey.

Table 5: Cancer Screening Trends by Age, 1987 and 2000

	25-39		40-49		50-64		65+	
	1987	2000	1987	2000	1987	2000	1987	2000
Women who had a Pap test within the last 3 years	87.4	89.2	78.5	86.6	69.2	83.7	48.5	64..6
Women who had a mammogram within the last 2 years	—	—	32.1	64.2	32.2	78.6	21.7	68.0
Home or office blood stool test within the last 3 years	—	—	—	—	26.2	36.5	28.5	43.2

Source: Judith Swan, et al., "Progress in Cancer Screening Practices in the United States," *Cancer*, Vol. 97, No. 6, Mar. 15, 2003.

Cancer Screening

Screening for illness is one of the most important preventative steps available to avoid serious and expensive health complications that can result from cancer and chronic diseases. The American Cancer Society recommends yearly Pap tests for women over 21, yearly mammograms for women over 40, yearly prostate exams for men over 50, and regular colorectal exams for both men and women over 50.⁷⁰

Prostate screening has yet to prove its value, but screening for cervical cancer, breast cancer, and colorectal cancer have proven incredibly effective at reducing incidence and mortality rates.⁷¹ Table 5 shows the results of a study that found between 1987 and 2000 Pap tests among women over 25 increased by 12.1 percent, mammograms increased by 140.9 percent, and fecal occult blood/colorectal examinations (FOB/CRE) increased by 45.2 percent.⁷² FOB/CRE screening rates remain far lower than Pap test or mammogram rates. Increased screening was most pronounced for those ages 50 to 64 and for those over 65.

Minnesotans report some of the highest rates of cancer screening. Those over 50 report the highest rate—66.3 percent—of having a sigmoidoscopy or a colonoscopy at least once.⁷³ Minnesota also tops the list for the rate of those over 50 reporting a sigmoidoscopy or a colonoscopy in the past five years or past 10 years. Further, Minnesota ranked high in the

rate of women having a Pap test in the past three years (tenth); the rate of women over 40 having a mammogram in the past two years (sixth); the rate of women over 50 having a mammogram in the past two years (second); and the rate of women over 40 having a clinical breast exam in the past two years (fifth).

Cholesterol Levels Declining

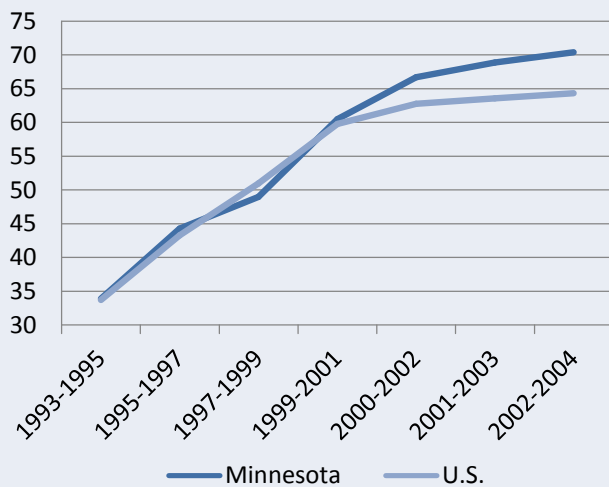
High cholesterol raises the risk of heart disease, a risk that is increasingly being reduced by more screening and wider use of cholesterol-lowering drugs. For the 18-and-over population in the United States, those reporting not having their cholesterol checked in the past five years dropped from a median state rate of 32.7 percent in 1993 to 27.5 percent in 2001.⁷⁴ The rate in Minnesota dropped from 31.1 percent to 23.8 percent.

Cholesterol-lowering drugs contributed to a measurable decline in the rate of high cholesterol among all adults. Between 1988 and 1994, the rate for elderly high cholesterol stood at 32.0 percent; for those 45 to 64, the rate was 30.4 percent.⁷⁵ By 1999-2003, elderly rates had dropped to 22.1 percent; for men and women 45 to 64, it had dropped to 22.6 percent.

Pneumonia and Flu Vaccinations

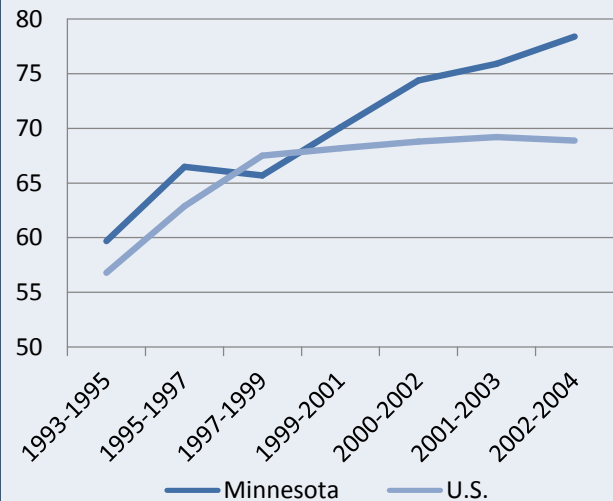
A simple shot can save a life, especially for the elderly who account for a majority of the vaccine-preventable deaths that occur each

Figure 18: Percent of Elderly Ever Having a Pneumonia Vaccination (3-year averages)



Source: Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System.

Figure 19: Percent of Elderly Who Received a Flu Shot in the Past Year (3-year averages)



Source: Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System.

year, including 90 percent of flu deaths.⁷⁶ Vaccinations are cheap and simple to administer, and so it is not surprising that the rate of elderly receiving pneumonia and flu vaccinations rose dramatically between 1993 and 2004. Over this time, the median state rate of elderly receiving a pneumonia vaccination almost doubled, rising from 33.7 percent to 64.4 percent, and in Minnesota the rate more than doubled, rising from 33.9 percent to 70.4 percent (see Figure 18).⁷⁷ Over the same period, the rate of elderly receiving flu shots also rose nationally from 56.8 percent to 68.9 percent and in Minnesota from 59.7 percent to 78.4 percent, the highest rate in the country (see Figure 19).

Unlike other preventative measures that can help people avoid many of the chronic diseases and disabilities that lead to expensive LTC, pneumonia and flu vaccinations might increase LTC costs by extending life and thereby extending time spent in a LTC facility. That is not to say vaccinations will not save money in other ways, for example, by cutting down on expensive hospital stays.

Healthy Living

To be most effective, preventative steps focused on healthy living, like exercise and nutrition, should be initiated long before old age sets in, and, for best effect, should be life habits instilled from the cradle on. Nonetheless, research proves the truism “better late than never” and shows that lifestyle changes, even late in life, can significantly improve health outcomes.

Many studies demonstrate the importance of a diet rich with vitamin- and antioxidant-rich fruits and vegetables. But over the past decade, BRFSS surveys show more and more people choosing to eat too-small amounts of produce, defined as less than three servings of fruits and vegetables per day. Between 1994 and 2003, every state posted an increase in the rate of people age 45 to 64 consuming insufficient amounts of these foods.⁷⁸ For the elderly, all but three states—Kentucky, Maryland, and Rhode Island—posted such an increase.

Minnesota boomer eating habits appear slightly less healthy than the rest of the nation, while the eating habits of elderly men and women in the state are slightly healthier. Of 45- to 64-

year-old Minnesotans, 39.2 percent consume fewer than three servings of fruits and vegetables per day, compared with a median rate of 38.8 percent in states across the country. Among the elderly, only 24.2 percent of Minnesotans eat unhealthily in this way, compared to a state median rate of 26.7 percent.

While eating habits deteriorate, it appears the exercise habits of boomers and the elderly are improving, an important fact since even moderate levels of physical activity can protect against chronic illness and extend life.⁷⁹ From 1994-1996 to 2002-2004, the median state rate for 45- to 65-year olds reporting any level of physical activity in a month improved from 68.5 to 76.5 percent, with median rates for the elderly improving from 58.2 percent to 66.8 percent. Minnesota remains the state to beat, finishing with the highest physical activity rate for both age groups in the 2002-2004 surveys.

Above all, ditching cigarettes and other tobacco products proves the most effective method for reducing behavior-related health risks. But the allure of nicotine continues to snare around 20 percent of adults—both nationally and in Minnesota—into lighting up, a number that has dropped only slightly in the past decade. Interestingly, a plausible argument can be made that higher tobacco use will result in lower LTC costs, since smokers tend to die before they can develop costlier age-related conditions.⁸⁰ At the very least, it seems safe to say that tobacco use, while impacting overall health immensely, affects LTC needs less than might be expected. Therefore, tobacco use may be a moot point in terms of LTC.

Overall, Boomers Can Expect Healthier Retirements, But Not Necessarily Less Need for LTC

The above facts and figures highlight many areas for health improvement, but on net, the data show boomers can expect healthier retirements. Life expectancies are up, death rates and disability rates are dropping, and

people are taking more preventative measures to maintain good health.

Improved health might lower future LTC costs. Gains in circulatory health likely will have the most measurable impact on near-term LTC needs. Death rates due to heart disease and strokes continue dropping. The prevalence of heart disease is also dropping for most ages. Since heart disease accounts for about a quarter of LTC costs, these gains might appreciably lower boomer demand for LTC. Lower disability rates provide further hope that boomers might demand less LTC, especially if optimistic projections of 1.5 percent reductions in disability rates hold true.

However, few other disease-specific trends show much improvement. Boomers have experienced slight drops in the prevalence of kidney disease, chronic bronchitis, and emphysema, but these drops are belied by the fact that the prevalence of kidney disease rose for elderly populations and that death rates from chronic lower respiratory disease rose over the past two decades.

Other diseases leading to high LTC demands continue to be major problems. Among the elderly, the incidence of Alzheimer's disease and diabetes continues to rise. And as noted, obesity is another immensely troubling health fact that could lead to higher LTC needs.

Thus, despite overall health gains, LTC costs may increase if the diseases that create the need for LTC become more prevalent. This fact highlights how important treating the specific diseases that lead to LTC will be in any strategy to keep boomer LTC budgets affordable.

We do not know if higher LTC needs resulting from Alzheimer's disease, some cancers, obesity, and other chronic conditions will overwhelm gains made in lowering disability rates and treating and preventing heart disease, but they might, and we need to financially prepare for that possibility.

Longevity Likely Will Increase LTC Costs

Studies find that increasing longevity will affect acute care and LTC expenditures quite differently.⁸¹ In general, research finds that better health might possibly lower acute care costs and that it will most likely raise LTC costs.

Intuitively, it seems longer life should impact acute care services more so than LTC services, since any added years will multiply the number of doctor appointments, hospital visits, and drug prescriptions, while added years, by themselves, should only change the timing of LTC. A number of academic studies, however, tell a different story.

Added years will indeed multiply the amount of acute care medical services utilized, but studies measuring impacts on Medicare show the added cost might be much less than expected. Medicare, it turns out, spends much less in the last year of life for those who die later in life.⁸² One study reaches the dramatic conclusion that cumulative per person lifetime spending on Medicare actually levels off by the age of 90, meaning the lifetime Medicare cost of someone who lives to 98 years is no more than the lifetime cost for someone living to 91 years.⁸³ To explain this dramatic result, the authors reason that the older elderly depend more on LTC to meet their health care needs and LTC is much less likely to be paid by Medicare.⁸⁴ Also, the older elderly are less motivated to take aggressive—i.e., expensive—steps in response to life threatening illness.

While spending on acute care at the time before death declines with age, the opposite holds true for LTC spending. According to one study, average nursing home and Medicaid expenditures in the last year of life are three times higher for those over 85 than for those 65 to 74.⁸⁵ Another study, estimating nursing home expenditures in the last two years of life, finds expenditures rise from \$6,000 for those who die at 75 to \$32,000 for those who die at 95.⁸⁶

Much of the LTC cost increase can be attributed to needing LTC for a longer time frame. One study modeled the impact of improved health and found that, while improved health increases longevity, improved health also increases the absolute number of days spent in a nursing home.⁸⁷

In light of Minnesota's higher proportion of elderly over 85 and high life expectancy, these data help explain Minnesota's higher nursing home utilization rate and suggest Minnesota will experience increasing LTC cost pressure from longer lives in the future.

Conclusion

Looking broadly at what the demographics and the health of boomers tell us, three lessons stand out.

- First, a strong economy, by keeping people in the workforce and by keeping their salaries growing, will guarantee more resources to pay for LTC and at the same time limit demand for those resources.
- Second, larger families also will add to the resources for LTC and lower demand for formal LTC by adding more people to the workforce and increasing the number of informal caregivers.
- Third, the health of boomers and the elderly is generally improving, but we cannot depend on such improvements to lessen the need for LTC. On one hand, they may lead to less need for LTC since they are tied to declines in circulatory system diseases and disability rates, which in turn, precipitate much less need for LTC. On the other hand, and as noted, studies likewise suggest that healthier, longer-living boomers will require *more* LTC.

Minnesota maintains some of the highest labor force participation rates and a better than average worker-to-retiree ratio. And on nearly every health measure documented in this report, Minnesota consistently ranks near the top, often perched above all others.

Minnesotans report the lowest adult rate of poor or fair health; the highest rate of colorectal cancer screening; the lowest percentage of elderly not getting flu shots; the highest physical activity rate for boomers and the elderly; the second highest life expectancy; the second lowest death rate; the third lowest diabetes rate, and the list could go on. It is no surprise that *America's Health Rankings*—an annual report published by the United Health Foundation—ranked Minnesota the healthiest state in eleven of the last seventeen years, including the most recent 2006 edition.⁸⁸

But all of this great health news may come at a price when Minnesota boomers begin needing LTC. One would hope that by having lower disability rates and heart health second to none, Minnesotans would also need less LTC, but Minnesotans utilize nursing homes at higher rates and Minnesota spends more per elderly Medicaid beneficiary than nearly any other state. Studies showing that longevity leads to higher LTC costs suggest Minnesota's better health might contribute to costlier LTC bills. Therefore, Minnesota must be especially vigilant in planning for potentially higher than average LTC costs.

Some may say that it is too late for policy solutions that address demographic and health issues. The boomers are already at retirement's threshold. But, assuming many boomers won't need LTC until they turn 85, the last of them will begin needing it around 2049, a long way off. Policies and personal practices begun today that make working and building businesses more attractive, that make families more robust, and that reduce health problems would indeed make a difference.

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APPENDIX

Table A1: Population Projections by Region, Division, State, and Age: 2000 and 2030

Area	0 to 17 Years				18 to 64 Years			
	2000 Census	2030 Projection	% Change	State Rank	2000 Census	2030 Projection	% Change	State Rank
US	72,293,812	85,707,297	18.6%		174,136,341	206,423,667	18.5%	
Northeast	13,047,783	12,619,092	-3.3%		33,174,313	32,880,707	-0.9%	
New England	3,347,897	3,371,664	0.7%		8,682,991	8,846,586	1.9%	
Connecticut	841,688	823,436	-2.2%	35	2,093,694	2,070,789	-1.1%	41
Maine	301,238	255,393	-15.2%	48	790,283	781,687	-1.1%	40
Massachusetts	1,500,064	1,545,614	3.0%	28	3,988,871	4,003,285	0.4%	36
New Hampshire	309,562	355,531	14.8%	19	778,254	938,154	20.5%	16
Rhode Island	247,822	252,731	2.0%	29	648,095	653,703	0.9%	35
Vermont	147,523	138,959	-5.8%	38	383,794	398,968	4.0%	26
Middle Atlantic	9,699,886	9,247,428	-4.7%		24,491,322	24,034,121	-1.9%	
New Jersey	2,087,558	2,175,752	4.2%	26	5,213,656	5,667,143	8.7%	22
New York	4,690,107	4,325,477	-7.8%	41	11,837,998	11,235,061	-5.1%	44
Pennsylvania	2,922,221	2,746,199	-6.0%	39	7,439,668	7,131,917	-4.1%	43
Midwest	16,647,666	16,555,433	-0.6%		39,486,035	40,083,495	1.5%	
East North Central	11,672,709	11,400,013	-2.3%		27,800,144	27,844,429	0.2%	
Illinois	3,245,451	3,259,113	0.4%	31	7,673,817	7,761,602	1.1%	33
Indiana	1,574,396	1,701,424	8.1%	24	3,753,258	3,876,811	3.3%	28
Michigan	2,595,767	2,433,329	-6.3%	40	6,123,659	6,180,118	0.9%	34
Ohio	2,888,339	2,640,671	-8.6%	44	6,957,044	6,552,835	-5.8%	46
Wisconsin	1,368,756	1,365,476	-0.2%	32	3,292,366	3,473,063	5.5%	25
West North Central	4,974,957	5,155,420	3.6%		11,685,891	12,239,066	4.7%	
Iowa	733,638	663,301	-9.6%	45	1,756,473	1,628,685	-7.3%	47
Kansas	712,993	708,946	-0.6%	33	1,619,196	1,638,047	1.2%	32
Minnesota	1,286,894	1,505,527	17.0%	17	3,038,319	3,607,479	18.7%	17
Missouri	1,427,692	1,497,099	4.9%	25	3,412,140	3,631,360	6.4%	24
Nebraska	450,242	456,338	1.4%	30	1,028,826	988,098	-4.0%	42
North Dakota	160,849	128,313	-20.2%	50	386,873	325,895	-15.8%	50
South Dakota	202,649	195,896	-3.3%	36	444,064	419,502	-5.5%	45
South	25,566,903	34,369,111	34.4%		62,231,650	80,574,377	29.5%	
South Atlantic	12,595,668	17,824,382	41.5%		32,286,080	43,481,726	34.7%	
Delaware	194,587	218,760	12.4%	21	487,287	556,075	14.1%	19
Dist. of Columbia	114,992	100,589	-12.5%	47	387,169	274,587	-29.1%	51
Florida	3,646,340	5,770,082	58.2%	3	9,528,441	15,146,235	59.0%	3
Georgia	2,169,234	3,146,624	45.1%	7	5,231,944	6,963,377	33.1%	9
Maryland	1,356,172	1,718,368	26.7%	15	3,341,007	4,068,188	21.8%	14
North Carolina	1,964,047	3,080,611	56.9%	4	5,116,218	6,973,955	36.3%	8
South Carolina	1,009,641	1,143,807	13.3%	20	2,517,038	2,870,303	14.0%	20
Virginia	1,738,262	2,320,190	33.5%	8	4,547,920	5,660,841	24.5%	12
West Virginia	402,393	325,351	-19.1%	49	1,129,056	968,165	-14.3%	49
East South Central	4,291,948	4,643,543	8.2%		10,599,437	11,264,357	6.3%	
Alabama	1,123,422	1,112,264	-1.0%	34	2,743,880	2,722,819	-0.8%	37
Kentucky	994,818	1,027,976	3.3%	27	2,542,158	2,623,572	3.2%	29
Mississippi	775,187	712,022	-8.1%	42	1,725,948	1,746,321	1.2%	31
Tennessee	1,398,521	1,791,281	28.1%	14	3,587,451	4,171,645	16.3%	18
West South Central	8,679,287	11,901,186	37.1%		19,346,133	25,828,294	33.5%	
Arkansas	680,369	783,223	15.1%	18	1,619,012	1,800,579	11.2%	21
Louisiana	1,219,799	1,149,939	-5.7%	37	2,732,248	2,708,482	-0.9%	39
Oklahoma	892,360	977,929	9.6%	23	2,102,344	2,177,769	3.6%	27
Texas	5,886,759	8,990,095	52.7%	5	12,892,529	19,141,464	48.5%	4
West	17,031,460	22,163,661	30.1%		38,488,613	51,551,431	33.9%	
Mountain	4,934,778	7,460,022	51.2%		10,451,941	15,206,028	45.5%	
Arizona	1,366,947	2,607,152	90.7%	2	3,095,846	5,733,891	85.2%	2
Colorado	1,100,795	1,464,836	33.1%	9	2,784,393	3,371,243	21.1%	15
Idaho	369,030	486,088	31.7%	11	779,007	1,122,503	44.1%	6
Montana	230,062	210,342	-8.6%	43	551,184	564,998	2.5%	30
Nevada	511,799	1,075,633	110.2%	1	511,799	1,075,633	110.2%	1
New Mexico	508,574	455,808	-10.4%	46	1,098,247	1,088,716	-0.9%	38
Utah	718,698	1,060,166	47.5%	6	1,324,249	1,964,648	48.4%	5
Wyoming	128,873	99,997	-22.4%	51	307,216	284,396	-7.4%	48
Pacific	12,096,682	14,703,639	21.6%		28,036,672	36,345,403	29.6%	
Alaska	190,717	249,293	30.7%	12	400,516	491,179	22.6%	13
California	9,249,829	11,046,140	19.4%	16	21,026,161	27,110,480	28.9%	11
Hawaii	295,767	325,503	10.1%	22	755,169	813,586	7.7%	23
Oregon	846,526	1,118,070	32.1%	10	2,136,696	2,833,891	32.6%	10
Washington	1,513,843	1,964,633	29.8%	13	3,718,130	5,096,267	37.1%	7

Source: U.S. Census Bureau, Interim State Population Projections, 2005.

Table A1: Population Projections by Region, Division, State, and Age: 2000 and 2030 (cont.)

Area	65-74				75-84			
	2000 Census	2030 Projection	% Change	State Rank	2000 Census	2030 Projection	% Change	State Rank
US	18,390,986	37,947,933	106.3%		12,361,180	23,902,504	93.4%	
Northeast	3,768,272	6,268,511	66.3%		2,665,551	4,071,309	52.7%	
New England	948,285	1,752,919	84.9%		689,939	1,148,515	66.5%	
Connecticut	231,565	395,444	70.8%	39	174,345	266,521	52.9%	44
Maine	96,196	190,490	98.0%	25	63,890	131,254	105.4%	22
Massachusetts	427,830	763,820	78.5%	32	315,640	487,351	54.4%	43
New Hampshire	78,327	189,201	141.6%	8	51,412	118,711	130.9%	12
Rhode Island	73,684	126,749	72.0%	37	57,821	82,846	43.3%	49
Vermont	40,683	87,215	114.4%	19	26,831	61,832	130.4%	14
Middle Atlantic	2,819,987	4,515,592	60.1%		1,975,612	2,922,794	47.9%	
New Jersey	574,669	1,027,274	78.8%	31	402,468	641,360	59.4%	37
New York	1,276,046	2,003,135	57.0%	46	860,818	1,291,985	50.1%	45
Pennsylvania	969,272	1,485,183	53.2%	49	712,326	989,449	38.9%	50
Midwest	4,247,710	7,216,959	69.9%		2,947,070	4,685,033	59.0%	
East North Central	2,956,079	4,907,755	66.0%		2,027,635	3,172,952	56.5%	
Illinois	772,247	1,258,942	63.0%	45	535,747	801,294	49.6%	47
Indiana	395,393	647,725	63.8%	43	265,880	415,014	56.1%	42
Michigan	642,880	1,090,442	69.6%	40	433,678	703,194	62.1%	36
Ohio	790,252	1,225,233	55.0%	48	540,709	809,292	49.7%	46
Wisconsin	355,307	685,413	92.9%	26	251,621	444,158	76.5%	30
West North Central	1,291,631	2,309,204	78.8%		919,435	1,512,081	64.5%	
Iowa	211,935	330,090	55.8%	47	159,160	228,119	43.3%	48
Kansas	175,916	300,649	70.9%	38	128,543	204,473	59.1%	38
Minnesota	295,825	626,678	111.8%	21	212,840	397,987	87.0%	26
Missouri	393,226	694,282	76.6%	34	263,582	433,236	64.4%	34
Nebraska	115,699	189,001	63.4%	44	82,543	130,624	58.2%	39
North Dakota	45,901	75,535	64.6%	42	33,851	53,521	58.1%	40
South Dakota	53,129	92,969	75.0%	36	38,916	64,121	64.8%	33
South	6,711,853	15,460,469	130.3%		4,295,868	9,331,409	117.2%	
South Atlantic	3,686,234	9,188,225	149.3%		2,420,833	5,503,828	127.4%	
Delaware	56,415	131,016	132.2%	12	34,762	77,812	123.8%	18
Dist. of Columbia	35,919	29,441	-18.0%	51	25,004	19,959	-20.2%	51
Florida	1,452,176	4,306,324	196.5%	3	1,024,134	2,519,453	146.0%	7
Georgia	435,695	1,067,953	145.1%	7	261,723	614,958	135.0%	11
Maryland	321,285	647,072	101.4%	23	211,120	411,910	95.1%	25
North Carolina	533,777	1,198,818	124.6%	16	329,810	707,474	114.5%	20
South Carolina	270,048	612,834	126.9%	14	165,016	380,339	130.5%	13
Virginia	432,456	974,059	125.2%	15	272,611	619,563	127.3%	16
West Virginia	148,463	220,708	48.7%	50	96,653	152,360	57.6%	41
East South Central	1,159,253	2,171,673	87.3%		722,254	1,330,752	84.2%	
Alabama	316,748	558,598	76.4%	35	195,749	348,492	78.0%	29
Kentucky	273,943	496,848	81.4%	30	172,589	300,550	74.1%	31
Mississippi	185,710	355,395	91.4%	27	114,922	205,026	78.4%	28
Tennessee	382,852	760,832	98.7%	24	238,994	476,684	99.5%	23
West South Central	1,866,366	4,100,571	119.7%		1,152,781	2,496,829	116.6%	
Arkansas	198,334	360,153	81.6%	29	129,193	213,926	65.6%	32
Louisiana	282,925	499,768	76.6%	33	175,328	318,229	81.5%	27
Oklahoma	242,499	403,068	66.2%	41	156,276	254,926	63.1%	35
Texas	1,142,608	2,837,582	148.3%	5	691,984	1,709,748	147.1%	6
West	3,663,151	9,001,994	145.7%		2,452,691	5,814,753	137.1%	
Mountain	1,111,051	3,196,364	187.7%		699,879	1,994,613	185.0%	
Arizona	363,841	1,317,759	262.2%	1	235,473	788,321	234.8%	3
Colorado	226,310	491,097	117.0%	18	141,547	333,146	135.4%	10
Idaho	75,970	188,338	147.9%	6	51,889	125,674	142.2%	8
Montana	62,519	133,804	114.0%	20	43,093	98,360	128.3%	15
Nevada	131,775	470,955	257.4%	2	70,165	243,651	247.3%	2
New Mexico	117,745	283,974	141.2%	9	71,174	195,581	174.8%	4
Utah	101,548	242,184	138.5%	11	66,923	158,899	137.4%	9
Wyoming	31,343	68,253	117.8%	17	19,615	50,981	159.9%	5
Pacific	2,552,100	5,805,630	127.5%		1,752,812	3,820,140	117.9%	
Alaska	22,507	64,238	185.4%	4	10,558	44,907	325.3%	1
California	1,887,823	4,332,266	129.5%	13	1,282,178	2,797,438	118.2%	19
Hawaii	85,262	159,457	87.0%	28	57,775	119,246	106.4%	21
Oregon	219,342	444,155	102.5%	22	161,404	316,061	95.8%	24
Washington	337,166	805,514	138.9%	10	240,897	542,488	125.2%	17

Source: U.S. Census Bureau, Interim State Population Projections, 2005.

Table A1: Population Projections by Region, Division, State, and Age: 2000 and 2030 (cont.)

Area	85+				65+			
	2000 Census	2030 Projection	% Change	State Rank	2000 Census	2030 Projection	% Change	State Rank
United States	4,239,587	9,603,034	126.5%		34,991,753	71,453,471	104.2%	
Northeast	938,459	1,831,449	95.2%		7,372,282	12,171,269	65.1%	
New England	253,405	503,331	98.6%		1,891,629	3,404,765	80.0%	
Connecticut	64,273	132,440	106.1%	28	470,183	794,405	69.0%	38
Maine	23,316	52,273	124.2%	23	183,402	374,017	103.9%	22
Massachusetts	116,692	211,939	81.6%	38	860,162	1,463,110	70.1%	37
New Hampshire	18,231	44,874	146.1%	21	147,970	352,786	138.4%	11
Rhode Island	20,897	36,912	76.6%	41	152,402	246,507	61.7%	43
Vermont	9,996	24,893	149.0%	20	77,510	173,940	124.4%	18
Middle Atlantic	685,054	1,328,118	93.9%		5,480,653	8,766,504	60.0%	
New Jersey	135,999	290,911	113.9%	26	1,113,136	1,959,545	76.0%	32
New York	311,488	621,771	99.6%	30	2,448,352	3,916,891	60.0%	46
Pennsylvania	237,567	415,436	74.9%	42	1,919,165	2,890,068	50.6%	50
Midwest	1,064,295	1,956,378	83.8%		8,259,075	13,858,370	67.8%	
East North Central	698,470	1,313,315	88.0%		5,682,184	9,394,022	65.3%	
Illinois	192,031	351,941	83.3%	35	1,500,025	2,412,177	60.8%	45
Indiana	91,558	169,134	84.7%	34	752,831	1,231,873	63.6%	41
Michigan	142,460	287,089	101.5%	29	1,219,018	2,080,725	70.7%	36
Ohio	176,796	322,497	82.4%	36	1,507,757	2,357,022	56.3%	47
Wisconsin	95,625	182,654	91.0%	33	702,553	1,312,225	86.8%	27
West North Central	365,825	643,063	75.8%		2,576,891	4,464,348	73.2%	
Iowa	65,118	104,977	61.2%	49	436,213	663,186	52.0%	49
Kansas	51,770	87,969	69.9%	46	356,229	593,091	66.5%	39
Minnesota	85,601	168,459	96.8%	31	594,266	1,193,124	100.8%	26
Missouri	98,571	174,196	76.7%	40	755,379	1,301,714	72.3%	34
Nebraska	33,953	56,186	65.5%	48	232,195	375,811	61.9%	42
North Dakota	14,726	23,302	58.2%	50	94,478	152,358	61.3%	44
South Dakota	16,086	27,974	73.9%	44	108,131	185,064	71.1%	35
South	1,430,546	3,533,971	147.0%		12,438,267	28,325,849	127.7%	
South Atlantic	780,345	2,095,055	168.5%		6,887,412	16,787,108	143.7%	
Delaware	10,549	28,995	174.9%	9	101,726	237,823	133.8%	13
Dist. of Columbia	8,975	8,838	-1.5%	51	69,898	58,238	-16.7%	51
Florida	331,287	943,675	184.9%	7	2,807,597	7,769,452	176.7%	4
Georgia	87,857	224,926	156.0%	18	785,275	1,907,837	143.0%	8
Maryland	66,902	176,713	164.1%	15	599,307	1,235,695	106.2%	21
North Carolina	105,461	266,881	153.1%	19	969,048	2,173,173	124.3%	19
South Carolina	50,269	141,286	181.1%	8	485,333	1,134,459	133.7%	14
Virginia	87,266	250,366	186.9%	6	792,333	1,843,988	132.7%	15
West Virginia	31,779	53,375	68.0%	47	276,895	426,443	54.0%	48
East South Central	249,918	491,960	96.8%		2,131,425	3,994,385	87.4%	
Alabama	67,301	132,070	96.2%	32	579,798	1,039,160	79.2%	30
Kentucky	58,261	106,052	82.0%	37	504,793	903,450	79.0%	31
Mississippi	42,891	73,646	71.7%	45	343,523	634,067	84.6%	28
Tennessee	81,465	180,192	121.2%	24	703,311	1,417,708	101.6%	24
West South Central	400,283	946,956	136.6%		3,419,430	7,544,356	120.6%	
Arkansas	46,492	82,327	77.1%	39	374,019	656,406	75.5%	33
Louisiana	58,676	126,215	115.1%	25	516,929	944,212	82.7%	29
Oklahoma	57,175	99,559	74.1%	43	455,950	757,553	66.1%	40
Texas	237,940	638,855	168.5%	14	2,072,532	5,186,185	150.2%	6
West	806,287	2,281,236	182.9%		6,922,129	17,097,983	147.0%	
Mountain	218,916	718,748	228.3%		2,029,846	5,909,725	191.1%	
Arizona	68,525	265,274	287.1%	3	667,839	2,371,354	255.1%	3
Colorado	48,216	132,035	173.8%	11	416,073	956,278	129.8%	17
Idaho	18,057	47,021	160.4%	16	145,916	361,033	147.4%	7
Montana	15,337	37,394	143.8%	22	120,949	269,558	122.9%	20
Nevada	16,989	82,573	386.0%	2	218,929	797,179	264.1%	1
New Mexico	23,306	75,629	224.5%	4	212,225	555,184	161.6%	5
Utah	21,751	59,470	173.4%	12	190,222	460,553	142.1%	9
Wyoming	6,735	19,352	187.3%	5	57,693	138,586	140.2%	10
Pacific	587,371	1,562,488	166.0%		4,892,283	11,188,258	128.7%	
Alaska	2,634	18,057	585.5%	1	35,699	127,202	256.3%	2
California	425,657	1,158,537	172.2%	13	3,595,658	8,288,241	130.5%	16
Hawaii	17,564	48,254	174.7%	10	160,601	326,957	103.6%	23
Oregon	57,431	121,741	112.0%	27	438,177	881,957	101.3%	25
Washington	84,085	215,899	156.8%	17	662,148	1,563,901	136.2%	12

Source: U.S. Census Bureau, Interim State Population Projections, 2005.

Table A2: Percent of Population Over 65 and Median Age by Region, Division, and State: 2000 and 2030

Area	Percent Over 65				Median Age			
	2000	Rank	2030	Rank	2000	Rank	2030	Rank
United States	12.4%		19.7%		35.31		39.01	
Northeast	13.8%		21.1%					
New England	13.6%		21.8%					
Connecticut	13.8%	10	21.5%	16	37.39	7	41.11	17
Maine	14.4%	7	26.5%	2	38.64	3	46.95	1
Massachusetts	13.5%	12	20.9%	21	36.55	12	40.24	21
New Hampshire	12.0%	37	21.4%	17	37.11	8	42.07	11
Rhode Island	14.5%	6	21.4%	18	36.73	10	40.73	20
Vermont	12.7%	26	24.4%	8	37.69	5	43.93	7
Middle Atlantic	13.8%		20.8%					
New Jersey	13.2%	18	20.0%	29	36.74	9	40.8	19
New York	12.9%	24	20.1%	28	35.86	25	39.88	25
Pennsylvania	15.6%	2	22.6%	11	38.01	4	42.12	10
Midwest	12.8%		19.7%					
East North Central	12.6%		19.3%					
Illinois	12.1%	34	18.0%	42	34.69	39	37.77	41
Indiana	12.4%	28	18.1%	41	35.21	36	37.67	42
Michigan	12.3%	30	19.5%	32	35.51	29	40.16	23
Ohio	13.3%	15	20.4%	24	36.22	15	40.2	22
Wisconsin	13.1%	20	21.3%	19	36.03	20	41.58	13
West North Central	13.4%		20.4%					
Iowa	14.9%	4	22.4%	12	36.64	11	41.98	12
Kansas	13.3%	17	20.2%	27	35.17	37	39.06	32
Minnesota	12.1%	33	18.9%	35	35.37	32	39.01	33
Missouri	13.5%	13	20.2%	26	36.11	18	39.56	27
Nebraska	13.6%	11	20.6%	22	35.31	34	38.44	37
North Dakota	14.7%	5	25.1%	6	36.16	17	43.17	9
South Dakota	14.3%	8	23.1%	10	35.58	28	41.49	14
South	12.4%		19.8%					
South Atlantic	13.3%		21.5%					
Delaware	13.0%	23	23.5%	9	36.02	21	43.6	8
Dist. of Columbia	12.2%	31	13.4%	50	34.64	40	33.74	49
Florida	17.6%	1	27.1%	1	38.7	2	45.43	5
Georgia	9.6%	49	15.9%	47	33.38	46	35.63	47
Maryland	11.3%	41	17.6%	45	36	22	37.51	43
North Carolina	12.0%	36	17.8%	44	35.31	34	36.77	45
South Carolina	12.1%	32	22.0%	15	35.44	31	41.3	15
Virginia	11.2%	44	18.8%	36	35.7	27	37.81	40
West Virginia	15.3%	3	24.8%	7	38.9	1	46.69	2
East South Central	12.5%		20.1%					
Alabama	13.0%	21	21.3%	20	35.85	26	41.01	18
Kentucky	12.5%	27	19.8%	30	35.87	24	39.97	24
Mississippi	12.1%	35	20.5%	23	33.81	45	41.12	16
Tennessee	12.4%	29	19.2%	34	35.89	23	38.33	38
West South Central	10.9%		16.7%					
Arkansas	14.0%	9	20.3%	25	36.05	19	39.79	26
Louisiana	11.6%	40	19.7%	31	34.04	44	38.81	34
Oklahoma	13.2%	19	19.4%	33	35.49	30	37.89	39
Texas	9.9%	47	15.6%	48	32.33	50	34.61	48
West	11.0%		18.6%					
Mountain	11.2%		19.8%					
Arizona	13.0%	22	22.1%	14	34.2	43	39.32	29
Colorado	9.7%	48	16.5%	46	34.32	42	35.65	46
Idaho	11.3%	42	18.3%	38	33.19	48	39.22	30
Montana	13.4%	14	25.8%	5	37.54	6	46.04	4
Nevada	11.0%	45	18.6%	37	35.03	38	39.36	28
New Mexico	11.7%	39	26.4%	4	34.56	41	44.78	6
Utah	8.5%	50	13.2%	51	27.14	51	30.42	51
Wyoming	11.7%	38	26.5%	3	36.22	15	46.41	3
Pacific	10.9%		18.0%					
Alaska	5.7%	51	14.7%	49	32.43	49	32.87	50
California	10.6%	46	17.8%	43	33.28	47	37.37	44
Hawaii	13.3%	16	22.3%	13	36.25	14	38.68	35
Oregon	12.8%	25	18.2%	39	36.33	13	39.11	31
Washington	11.2%	43	18.1%	40	35.35	33	38.5	36

Source: U.S. Census Bureau, Interim State Population Projections, 2005.

Table A3: Internal Migration from 1995 to 2000 Within the United States by Region, Division, and State

Area	Total, 65 and over			65 to 74			75 to 84			85 and over		
	Net Migration	Net Migration Rate	State Rank	Net Migration	Net Migration rate	State Rank	Net Migration	Net migration rate	State Rank	Net Migration	Net Migration rate	State Rank
Northeast	-175,814	-23.5		-122,249	-31.5		-40,986	-15.2		-12,579	-13.6	
New England	-22,286	-11.7		-21,195	-21.9		-2,665	-3.9		1,574	6.4	
Maine	1,650	9.1	12	195	2	20	749	11.9	10	706	31.9	4
Vermont	19	0.2	25	-230	-5.6	29	30	1.1	22	219	22.6	13
New Hampshire	720	4.9	19	61	0.8	24	168	3.3	19	491	27.1	9
Massachusetts	-14,434	-16.6	44	-11,014	-25.2	44	-2,619	-8.3	42	-801	-7	41
Rhode Island	-748	-4.9	32	-1,029	-13.8	37	-10	-0.2	25	291	14.4	19
Connecticut	-9,493	-20	46	-9,178	-38.4	48	-983	-5.6	40	668	10.7	24
Middle Atlantic	-153,528	-27.5		-101,054	-34.7		-38,321	-19.2		-14,153	-20.8	
New York	-114,171	-45	50	-71,721	-53.6	49	-29,666	-33.6	50	-12,784	-40.5	50
New Jersey	-23,151	-20.6	47	-18,239	-31	46	-4,496	-11.1	46	-738	-5.5	38
Pennsylvania	-15,884	-8.2	37	-11,094	-11.3	34	-4,159	-5.8	41	-631	-2.7	32
Midwest	-108,601	-13		-85,036	-31.5		-19,290	-6.5		-4,275	-4.1	
East North Central	-93,934	-16.3		-72,125	-23.8		-17,351	-8.5		-4,458	-6.5	
Ohio	-18,589	-12.2	42	-15,328	-18.9	41	-2,717	-5	38	-544	-3.2	33
Indiana	-6,315	-8.3	38	-6,556	-16.3	40	214	0.8	23	27	0.3	29
Illinois	-43,119	-28.1	48	-29,500	-36.9	47	-10,047	-18.5	48	-3,572	-18.8	47
Michigan	-21,949	-17.7	45	-16,697	-25.3	45	-4,385	-10.1	45	-867	-6.1	39
Wisconsin	-3,962	-5.6	33	-4,044	-11.2	33	-416	-1.7	29	498	5.4	27
West North Central	-14,667	-5.7		-12,911	-9.9		-1,939	-2.1		183	0.5	
Minnesota	-6,137	-10.3	40	-6,107	-20.2	42	-826	-3.9	34	796	9.4	25
Iowa	-4,927	-11.2	41	-3,460	-16	39	-1,508	-9.4	44	41	0.6	28
Missouri	513	0.7	24	586	1.5	22	539	2.1	20	-612	-6.3	40
North Dakota	-1,546	-16.1	43	-624	-13.4	36	-586	-17	47	-336	-22.5	49
South Dakota	-246	-2.3	28	-230	-4.3	25	-16	-0.4	26	0	0	30
Nebraska	-1,889	-8.1	36	-1,477	-12.6	35	-272	-3.3	33	-140	-4.2	36
Kansas	-435	-1.2	27	-1,599	-9	32	730	5.7	17	434	8.7	26
South	232,779	19.2		180,075	27.6		44,479	10.6		8,225	5.9	
South Atlantic	199,158	30		154,017	43.7		37,738	16		7,403	9.8	
Delaware	2,679	27.2	5	2,141	39.4	5	316	9.3	13	222	21.9	15
Maryland	-4,388	-7.3	35	-7,878	-24	43	1,576	7.6	16	1,914	30.5	5
District of Columbia	-5,187	-69.5	51	-2,235	-58.5	50	-1,699	-63.7	51	-1,253	-128.9	51
Virginia	6,937	8.9	13	1,795	4.2	18	2,673	10	12	2,469	29.8	6
West Virginia	-931	-3.4	30	244	1.6	21	-489	-5.1	39	-686	-21.2	48
North Carolina	20,922	22.1	6	13,467	25.7	6	4,873	15.1	7	2,582	26	11
South Carolina	15,760	33.6	4	11,882	45.6	4	2,758	17.3	5	1,120	23.2	12
Georgia	13,926	18.1	8	6,590	15.2	12	5,132	20.3	4	2,204	26.3	10
Florida	149,440	56.9	3	128,011	97.8	3	22,598	22.8	3	-1,169	-3.6	34
East South Central	14,566	6.9		13,507	11.7		1,980	2.8		-921	-3.8	
Kentucky	-1,397	-2.8	29	253	0.9	23	-754	-4.4	37	-896	-15.6	45
Tennessee	10,499	15.2	9	6,205	16.4	11	3,091	13.2	8	1,203	15.4	17
Alabama	3,031	5.3	18	3,662	11.6	13	-73	-0.4	26	-558	-8.4	42
Mississippi	2,433	7.1	16	3,387	18.3	10	-284	-2.5	32	-670	-15.4	44
West South Central	19,055	5.7		12,551	6.8		4,761	4.2		1,743	4.5	
Arkansas	2,496	6.7	17	4,382	22.5	8	-1,136	-8.8	43	-750	-16.3	46
Louisiana	-2,472	-4.8	31	-1,465	-5.1	27	-693	-4	35	-314	-5.4	37
Oklahoma	1,074	2.4	22	1,529	6.3	16	-249	-1.6	28	-206	-3.7	35
Texas	17,957	8.8	14	8,105	7.2	15	6,839	10.1	11	3,013	13.3	21
West	51,636	7.6		27,210	7.6		15,797	6.6		8,629	11.1	
Mountain	85,677	44.4		59,575	56.8		20,254	30.1		5,848	28	
Montana	891	7.4	15	311	5	17	383	9	15	197	13.1	22
Idaho	2,795	19.6	7	1,715	23.1	7	819	16.1	6	261	14.8	18
Wyoming	-29	-0.5	26	-172	-5.5	28	-36	-1.8	30	179	27.4	8
Colorado	1,994	4.8	20	-1,095	-4.8	26	1,282	9.2	14	1,807	40	3
New Mexico	2,500	12	10	2,157	18.6	9	93	1.3	21	250	11.1	23
Arizona	53,241	87.4	2	40,371	125.5	2	11,401	51.5	2	1,469	22.2	14
Utah	2,096	11.2	11	928	9.2	14	804	12.3	9	364	17.3	16
Nevada	22,189	114.2	1	15,360	132.7	1	5,508	86.6	1	1,321	88	1
Pacific	-34,041	-7		-32,365	-12.7		-4,457	-2.6		2,781	4.9	
Washington	1,170	1.8	23	-2,278	-6.8	30	1,244	5.2	18	2,204	27.7	7
Oregon	1,340	3.1	21	586	2.7	19	2	0	24	752	13.6	20
California	-34,171	-9.6	39	-28,690	-15.2	38	-5,383	-4.3	36	-98	-0.2	31
Alaska	-1,428	-39.4	49	-1,375	-59.3	51	-211	-20	49	158	62.5	2
Hawaii	-952	-6	34	-608	-7.1	31	-109	-1.9	31	-235	-13.3	43

Source: Wan He and Jason P. Schachter, Internal Migration of the Older Population: 1995 to 2000, *Census 2000 Special Reports 10*, U.S. Census Bureau, August 2003.

**Table A4: Fertility Rates, Live Births per 1,000 Women Ages 15-44,
United States and Minnesota**

Year	United States	Minnesota	Year	United States	Minnesota
1910	126.8		1958	120.0	
1911	126.3		1959	118.8	
1912	125.8		1960	118.0	136.0
1913	124.7		1961	117.1	
1914	126.6		1962	112.0	
1915	125.0		1963	108.3	
1916	123.4		1964	104.7	
1917	121.0		1965	96.3	105.9
1918	119.8		1966	90.8	
1919	111.2		1967	87.2	
1920	117.9		1968	85.2	
1921	119.8		1969	86.1	
1922	111.2		1970	87.9	88.4
1923	110.5		1971	81.6	
1924	110.9		1972	73.1	
1925	106.6		1973	68.8	
1926	102.6		1974	67.8	
1927	99.8		1975	66.0	65.4
1928	93.8		1976	65.0	
1929	89.3		1977	66.8	
1930	89.2		1978	65.5	
1931	84.6		1979	67.2	
1932	81.7		1980	68.4	70.8
1933	76.3		1981	67.3	
1934	78.5		1982	67.3	
1935	77.2		1983	65.7	
1936	75.8		1984	65.5	
1937	77.1		1985	66.3	68.0
1938	79.1		1986	65.4	65.9
1939	77.6		1987	65.8	64.9
1940	79.9	81.0	1988	67.3	65.4
1941	83.4		1989	69.2	65.9
1942	91.5		1990	70.9	66.3
1943	94.3		1991	69.3	64.7
1944	88.8		1992	68.4	62.5
1945	85.9	85.1	1993	67.0	61.0
1946	101.9		1994	65.9	59.9
1947	113.3		1995	64.6	60.1
1948	107.3		1996	64.1	59.7
1949	107.1		1997	63.6	61.4
1950	106.2	119.1	1998	64.3	61.8
1951	111.4		1999	64.4	62.5
1952	113.8		2000	65.9	62.3
1953	115.0		2001	65.3	60.9
1954	117.9		2002	64.8	62.0
1955	118.3	130.1	2003	66.1	64.1
1956	121.0		2004	66.3	64.5
1957	122.7				

* Live Births per 1,000 Female Population Age 15-44.

Sources: National Center for Health Statistics, *Vital Statistics of the United States, 2001, Vol I, Natality*; and Minnesota Department of Health, *2004 Minnesota Health Statistics Annual Summary*, November 2005.

Table A5: Marital Status of Men Ages 45 to 64 and 65+ by State, 2000

State	Never married				Widowed				Divorced			
	45 to 64 years	State Rank	65+	State Rank	45 to 64 years	State Rank	65+	State Rank	45 to 64 years	State Rank	65+	State Rank
Alabama	6.38%	12	3.19%	9	2.01%	47	14.28%	35	14.32%	26	6.68%	25
Alaska	9.89%	46	5.49%	41	1.37%	11	12.49%	6	17.13%	50	10.43%	49
Arizona	7.40%	24	2.54%	3	1.77%	33	12.61%	9	16.60%	44	7.50%	41
Arkansas	5.20%	3	2.96%	5	1.88%	42	12.52%	7	14.52%	29	6.92%	31
California	10.10%	47	4.78%	35	1.65%	23	13.13%	18	14.25%	24	8.23%	46
Colorado	7.73%	28	3.19%	10	1.38%	12	12.42%	5	15.87%	42	7.96%	44
Connecticut	8.95%	42	5.88%	45	1.56%	19	14.46%	37	12.97%	14	6.15%	18
Delaware	8.17%	34	4.14%	26	2.00%	46	14.27%	32	13.66%	20	6.01%	15
D.C.	27.24%	51	13.51%	51	2.98%	51	18.23%	51	16.89%	48	12.59%	51
Florida	7.93%	30	3.10%	7	1.87%	40	12.86%	14	16.70%	46	7.24%	37
Georgia	6.72%	17	3.53%	17	1.87%	41	13.55%	24	14.03%	23	6.89%	30
Hawaii	12.73%	50	6.49%	47	1.35%	9	11.83%	2	13.93%	21	6.88%	29
Idaho	4.88%	2	2.25%	2	1.23%	2	11.92%	3	15.01%	38	7.27%	38
Illinois	8.91%	40	5.40%	40	1.74%	32	14.73%	39	12.88%	12	6.38%	20
Indiana	6.04%	10	3.20%	11	1.48%	18	14.27%	33	14.77%	33	6.54%	21
Iowa	6.54%	13	4.14%	25	1.39%	13	12.85%	13	12.94%	13	4.87%	2
Kansas	5.92%	7	3.65%	19	1.25%	3	13.02%	15	13.94%	22	5.78%	10
Kentucky	5.84%	6	3.52%	16	1.85%	37	14.28%	34	14.47%	28	6.93%	32
Louisiana	8.40%	36	4.42%	29	2.33%	49	15.64%	46	14.39%	27	6.96%	34
Maine	6.83%	20	4.73%	34	1.41%	14	14.83%	42	15.72%	41	7.33%	39
Maryland	8.93%	41	5.06%	36	1.78%	34	14.77%	40	11.98%	5	6.23%	19
Massachusetts	10.86%	48	6.87%	48	1.63%	22	15.14%	44	12.31%	7	5.81%	13
Michigan	7.88%	29	4.21%	27	1.67%	26	14.56%	38	14.83%	35	6.80%	27
Minnesota	8.29%	35	5.32%	39	1.30%	4	12.66%	10	13.06%	15	5.78%	9
Mississippi	7.72%	27	3.97%	22	2.33%	50	15.68%	47	14.29%	25	7.02%	35
Missouri	6.57%	15	3.79%	20	1.71%	29	13.70%	28	14.88%	36	6.66%	23
Montana	6.72%	18	4.60%	32	1.57%	20	13.21%	20	15.59%	40	7.78%	43
Nebraska	6.82%	19	4.72%	33	1.41%	15	12.82%	12	12.79%	10	5.18%	4
Nevada	8.73%	38	4.44%	31	1.80%	36	13.68%	27	20.45%	51	12.26%	50
New Hampshire	6.57%	16	4.43%	30	1.58%	21	13.80%	30	14.79%	34	6.94%	33
New Jersey	8.98%	43	5.69%	42	1.71%	30	15.69%	48	10.59%	1	5.34%	7
New Mexico	8.47%	37	4.00%	24	1.86%	39	13.74%	29	16.91%	49	8.40%	47
New York	11.52%	49	7.06%	49	1.90%	45	15.12%	43	11.31%	2	5.85%	14
North Carolina	6.55%	14	3.26%	12	1.90%	44	13.18%	19	12.65%	9	5.79%	12
North Dakota	8.86%	39	7.32%	50	1.43%	16	12.61%	8	11.84%	4	4.44%	1
Ohio	7.34%	23	3.93%	21	1.69%	27	14.79%	41	14.67%	31	6.67%	24
Oklahoma	5.36%	4	2.56%	4	1.72%	31	13.03%	16	15.48%	39	7.46%	40
Oregon	6.92%	21	3.04%	6	1.33%	7	13.26%	21	16.78%	47	8.40%	48
Pennsylvania	9.01%	44	5.71%	43	1.86%	38	15.42%	45	11.77%	3	5.08%	3
Rhode Island	9.37%	45	6.25%	46	1.67%	25	16.01%	50	13.32%	17	6.11%	17
South Carolina	7.01%	22	3.63%	18	2.09%	48	14.38%	36	12.82%	11	5.78%	11
South Dakota	8.06%	32	5.78%	44	1.45%	17	12.18%	4	13.36%	18	5.30%	5
Tennessee	6.03%	9	3.28%	13	1.80%	35	13.66%	26	14.92%	37	6.79%	26
Texas	6.01%	8	3.12%	8	1.70%	28	13.09%	17	13.59%	19	6.85%	28
Utah	4.64%	1	2.03%	1	1.17%	1	11.49%	1	12.37%	8	5.30%	6
Vermont	7.98%	31	5.28%	38	1.31%	6	13.83%	31	14.58%	30	7.24%	36
Virginia	7.49%	25	3.99%	23	1.67%	24	13.60%	25	12.13%	6	6.07%	16
Washington	7.49%	26	3.38%	14	1.31%	5	12.73%	11	16.15%	43	8.06%	45
West Virginia	6.33%	11	4.33%	28	1.89%	43	15.81%	49	14.69%	32	6.65%	22
Wisconsin	8.14%	33	5.23%	37	1.36%	10	13.38%	22	13.23%	16	5.68%	8
Wyoming	5.40%	5	3.46%	15	1.34%	8	13.51%	23	16.70%	45	7.75%	42
United States	8.11%		4.40%		1.71%		13.90%		13.89%		6.71%	

Source: U.S. Census Bureau, Census 2000, Summary File 3, Table PCT7: Sex by Marital Status by Age for the Population 15 Years and Over.

Table A6: Marital Status of Women Ages 45 to 64 and 65+ by State, 2000

State	Never Married				Widowed				Divorced			
	45 to 64 years	State Rank	65+	State Rank	45 to 64 years	State Rank	65+	State Rank	45 to 64 years	State Rank	65+	State Rank
Alabama	5.60%	26	3.31%	17	8.81%	47	50.12%	49	16.49%	17	6.70%	14
Alaska	5.13%	15	2.78%	11	5.78%	15	41.60%	8	19.35%	43	12.49%	51
Arizona	5.49%	21	2.58%	10	6.26%	19	39.29%	1	20.29%	48	8.52%	43
Arkansas	3.89%	4	2.25%	6	7.84%	44	47.32%	42	16.47%	16	6.18%	11
California	7.92%	41	4.00%	29	6.69%	25	42.70%	12	19.12%	42	10.42%	47
Colorado	5.69%	27	2.89%	13	4.92%	1	41.48%	5	20.31%	49	10.44%	48
Connecticut	8.19%	44	6.53%	47	5.96%	17	44.34%	18	17.41%	30	7.18%	25
Delaware	7.04%	39	4.13%	34	7.20%	34	45.41%	26	17.90%	35	6.86%	18
D.C.	24.91%	51	12.58%	51	10.17%	51	47.77%	43	21.82%	50	11.99%	49
Florida	5.58%	25	2.95%	14	7.30%	37	41.58%	6	19.86%	44	7.94%	41
Georgia	6.06%	30	3.49%	21	7.83%	43	49.55%	48	18.36%	41	7.41%	28
Hawaii	8.95%	48	5.00%	43	6.88%	28	40.24%	3	16.69%	19	7.44%	29
Idaho	2.97%	1	1.56%	2	5.20%	4	41.60%	7	17.11%	25	7.77%	36
Illinois	7.94%	43	4.99%	42	7.18%	33	46.73%	38	16.53%	18	7.14%	23
Indiana	5.18%	17	3.20%	16	6.36%	22	46.65%	35	17.36%	28	7.52%	30
Iowa	4.88%	10	4.01%	30	5.60%	11	45.56%	29	14.98%	5	5.27%	3
Kansas	4.26%	7	3.11%	15	5.76%	14	44.84%	21	16.77%	21	6.95%	20
Kentucky	4.83%	9	3.94%	27	8.11%	45	48.70%	46	16.82%	22	6.88%	19
Louisiana	7.39%	40	4.10%	32	9.28%	49	49.37%	47	17.56%	32	7.10%	22
Maine	5.78%	28	4.74%	39	5.87%	16	44.81%	20	18.31%	40	7.77%	38
Maryland	8.73%	47	4.77%	40	7.28%	36	46.72%	37	16.88%	23	7.66%	32
Massachusetts	9.84%	49	8.13%	50	6.34%	21	44.96%	22	16.90%	24	6.74%	15
Michigan	6.65%	37	4.01%	31	6.65%	24	45.75%	30	17.99%	37	7.83%	39
Minnesota	6.51%	35	4.67%	38	4.92%	2	44.14%	16	15.61%	11	5.99%	9
Mississippi	6.61%	36	3.48%	20	9.54%	50	52.49%	51	16.17%	15	6.29%	13
Missouri	5.54%	23	3.61%	25	6.89%	29	46.17%	32	17.33%	27	7.35%	27
Montana	3.96%	5	2.19%	5	5.74%	13	44.21%	17	17.25%	26	7.73%	34
Nebraska	5.25%	19	3.59%	23	5.69%	12	45.22%	24	15.33%	9	5.73%	6
Nevada	4.96%	12	2.17%	4	6.93%	31	40.65%	4	22.17%	51	12.07%	50
New Hampshire	5.53%	22	4.90%	41	5.47%	8	42.94%	13	17.39%	29	7.77%	37
New Jersey	8.43%	46	6.01%	46	7.33%	38	47.27%	41	15.12%	6	6.28%	12
New Mexico	6.74%	38	3.47%	19	6.78%	26	42.04%	10	19.87%	45	9.89%	46
New York	10.98%	50	7.91%	49	7.64%	40	46.41%	34	15.53%	10	6.84%	17
North Carolina	5.54%	24	3.61%	26	7.80%	42	47.03%	40	15.76%	13	6.10%	10
North Dakota	4.60%	8	4.00%	28	6.17%	18	46.71%	36	12.98%	1	3.78%	1
Ohio	6.43%	33	4.23%	36	6.82%	27	46.12%	31	17.70%	34	7.74%	35
Oklahoma	3.58%	3	2.29%	7	7.40%	39	45.09%	23	18.27%	39	7.93%	40
Oregon	5.24%	18	2.48%	8	5.26%	6	42.63%	11	20.00%	46	9.46%	44
Pennsylvania	7.93%	42	5.99%	45	7.21%	35	46.27%	33	14.69%	3	5.47%	4
Rhode Island	8.29%	45	7.28%	48	6.52%	23	45.42%	27	18.08%	38	6.80%	16
South Carolina	5.84%	29	3.56%	22	8.89%	48	48.60%	45	15.15%	7	5.50%	5
South Dakota	4.92%	11	3.59%	24	6.27%	20	45.40%	25	14.13%	2	4.74%	2
Tennessee	5.17%	16	3.32%	18	7.71%	41	47.90%	44	17.63%	33	7.23%	26
Texas	4.99%	14	2.88%	12	7.17%	32	45.43%	28	17.52%	31	7.96%	42
Utah	4.19%	6	2.02%	3	4.93%	3	39.89%	2	15.18%	8	7.06%	21
Vermont	6.39%	31	5.08%	44	5.37%	7	44.80%	19	17.94%	36	7.68%	33
Virginia	6.46%	34	4.10%	33	6.89%	30	46.86%	39	15.96%	14	7.16%	24
Washington	5.34%	20	2.49%	9	5.21%	5	41.94%	9	20.11%	47	9.73%	45
West Virginia	4.96%	13	4.15%	35	8.74%	46	50.75%	50	14.84%	4	5.98%	8
Wisconsin	6.40%	32	4.32%	37	5.57%	10	44.09%	15	15.62%	12	5.98%	7
Wyoming	3.56%	2	1.46%	1	5.47%	9	43.84%	14	16.74%	20	7.63%	31
United States	6.79%		4.32%		6.98%		45.31%		17.37%		7.54%	

Source: U.S. Census Bureau, Census 2000, Summary File 3, Table PCT7: Sex by Marital Status by Age for the Population 15 Years and Over.

Table A7: Marital Status Trends in the United States and Minnesota, 1950 to 2000															
Men							Women								
Ages 45 to 64, United States							Ages 45 to 64, United States								
	1950	1960	1970	1980	1990	2000				1950	1960	1970	1980	1990	2000
Never Married	8.46%	7.68%	6.43%	5.72%	6.25%	8.11%			Never Married	7.77%	7.43%	6.10%	4.78%	5.10%	6.79%
Widowed	4.93%	3.19%	2.75%	2.46%	2.16%	1.71%			Widowed	17.02%	14.66%	13.43%	12.50%	10.15%	6.98%
Divorced	2.80%	3.06%	3.80%	6.30%	10.58%	13.89%			Divorced	3.03%	4.00%	5.29%	8.35%	13.53%	17.37%
Ages 45 to 64, Minnesota							Ages 45 to 64, Minnesota								
	1950	1960	1970	1980	1990	2000				1950	1960	1970	1980	1990	2000
Never Married	—	—	—	6.61%	6.17%	8.29%			Never Married	—	—	—	4.61%	4.59%	6.51%
Widowed	—	—	—	1.82%	1.58%	1.30%			Widowed	—	—	—	10.34%	7.80%	4.92%
Divorced	—	—	—	5.13%	9.40%	13.06%			Divorced	—	—	—	6.51%	11.44%	15.61%
Ages 65 and Over, United States							Ages 65 and Over, United States								
	1950	1960	1970	1980	1990	2000				1950	1960	1970	1980	1990	2000
Never Married	8.31%	7.75%	7.49%	5.50%	4.93%	4.40%			Never Married	8.89%	8.52%	8.13%	6.65%	5.49%	4.32%
Widowed	24.32%	19.21%	17.10%	14.57%	14.18%	13.90%			Widowed	54.37%	52.11%	52.22%	51.71%	49.40%	45.31%
Divorced	1.86%	2.35%	3.04%	3.65%	4.82%	6.71%			Divorced	1.11%	2.04%	3.19%	4.18%	5.50%	7.54%
Ages 65 and Over, Minnesota							Ages 65 and Over, Minnesota								
	1950	1960	1970	1980	1990	2000				1950	1960	1970	1980	1990	2000
Never Married	—	—	—	9.30%	7.23%	5.32%			Never Married	—	—	—	9.02%	6.71%	4.67%
Widowed	—	—	—	14.14%	13.03%	12.66%			Widowed	—	—	—	49.63%	48.58%	44.14%
Divorced	—	—	—	2.96%	3.83%	5.78%			Divorced	—	—	—	3.33%	4.25%	5.99%
Source: Author calculations derived from U.S. Census Bureau, Subject Reports, <i>Marital Status</i> , 1950 (Report P-E No. 2D), 1960 (Report PC(2)-4E), and 1970 (Report PC(2)-4C); U.S. Census Bureau, 1980 Census Subject Reports, <i>Marital Characteristics</i> , Report PC80-2-4C; U.S. Census Bureau, 1980 Census, <i>Detailed Population Characteristics</i> , Minnesota, Report C80-1-D25; U.S. Census Bureau, 1990 Census, <i>General Population Characteristics</i> , United States, Report 1990 CP-1-1; U.S. Census Bureau, 1990 Census, <i>General Population Characteristics</i> , Minnesota, Report 1990 CP-1-25; and U.S. Census Bureau, 2000 Census, Summary File 3, <i>Table PCT7: Sex by Marital Status by Age for the Population 15 Years and Over</i> , and U.S. Census Bureau, 2000 Census, Summary File 3, <i>Table P8: Sex by Age</i> .															

Table A8: Distribution of Long-Term Care Costs Among Veterans, 2000

65 to 79 Years				80 Years and Over			
Chronic Condition	Mean Cost	Total Cost	Percent of Total LTC Costs	Chronic Condition	Mean LTC Cost	Total Cost	Percent of Total LTC Costs
Dementia	5,785	98,865,650	11.23%	Dementia	6,934	79,304,158	15.66%
Congestive heart failure	1,055	77,311,455	8.78%	Alzheimer's disease	10,522	58,239,270	11.50%
Psychoses	1,921	72,448,594	8.23%	Congestive heart failure	2,123	53,686,424	10.60%
Renal failure	2,042	71,612,940	8.13%	Renal failure	3,147	36,826,194	7.27%
Alzheimer's disease	9,006	64,464,948	7.32%	Psychoses	3,949	30,683,730	6.06%
Cerebrovascular disease/stroke	1,642	52,701,632	5.98%	Cerebrovascular disease/stroke	2,620	23,454,240	4.63%
Cancer, not otherwise listed	1,203	40,850,271	4.64%	Parkinson's disease	3,879	21,691,368	4.28%
Peripheral vascular disease	705	38,041,095	4.32%	Chronic obstructive pulmonary disease	1,135	21,128,025	4.17%
Chronic obstructive pulmonary disease	410	37,186,590	4.22%	Peripheral vascular disease	1,505	20,425,860	4.03%
Alcoholism	1,722	37,002,336	4.20%	Cancer, not otherwise listed	2,009	16,397,458	3.24%
Parkinson's disease	2,320	34,468,240	3.91%	Ischemic heart disease	435	14,877,870	2.94%
Spinal cord injury	6,113	33,016,313	3.75%	Diabetes mellitus	687	11,537,478	2.28%
Lung cancer	1,938	31,918,860	3.62%	Prostate cancer	665	10,861,445	2.14%
Diabetes mellitus	229	24,453,307	2.78%	Lung cancer	2,850	9,667,200	1.91%
Ischemic heart disease	134	20,828,156	2.37%	Hypertension	462	9,531,060	1.88%
Prostate cancer	268	14,681,308	1.67%	Spinal cord injury	9,424	9,358,032	1.85%
Hypertension	126	12,831,840	1.46%	Alcoholism	4,283	7,906,418	1.56%
Multiple sclerosis	5,064	8,912,640	1.01%	Arthritis	412	6,198,128	1.22%
Colorectal cancer	626	8,338,946	0.95%	Colorectal cancer	1,380	5,289,540	1.04%
Arthritis	103	6,216,771	0.71%	Benign prostatic hyperplasia	484	4,582,996	0.90%
Depression	202	4,901,328	0.56%	Acid-related disorders	523	3,543,848	0.70%
Acid-related disorders	140	4,497,640	0.51%	Multiple sclerosis	7,596	1,785,060	0.35%
Benign prostatic hyperplasia	101	4,171,401	0.47%	Lower back pain	320	1,671,680	0.33%
Lower back pain	65	1,732,445	0.20%	Depression	286	1,220,648	0.24%
Asthma	86	1,594,526	0.18%	Asthma	179	590,879	0.12%
Headache	120	1,115,520	0.13%	Hepatitis C	1,196	307,372	0.06%
AIDS/HIV	1,014	1,055,574	0.12%	Substance abuse	359	238,735	0.05%
Hepatitis C	414	984,492	0.11%	Headache	141	206,424	0.04%
Substance abuse	108	911,952	0.10%	AIDS/HIV	1,465	111,340	0.02%
0 of 29 chronic conditions	395	73,462,890	8.34%	0 of 29 chronic conditions	872	45,187,040	8.92%
≥1 of 29 chronic conditions	736	807,804,160		≥1 of 29 chronic conditions	1,765	461,418,655	
Total LTC Costs		\$880,579,660		Total LTC Costs		\$506,509,920	

Source: Author calculations derived from Wei Yu, et al., "The Relationships Among Age, Chronic Conditions, and Healthcare Costs," *The American Journal of Managed Care*, Vol. 10, No. 12, December 2004.

Table A9: Percent of Population Reporting Poor or Fair Health by State (three-year averages)

State	45 to 64				65 to 74				75 and Over			
	1993-1995	2002-2004	State Rank	Percent Change	1993-1995	2002-2004	State Rank	Percent Change	1993-1995	2002-2004	State Rank	Percent Change
Alabama	22.2	24.8	47	11.7%	34.5	38.4	49	11.3%	46.1	44.5	49	-3.5%
Alaska	11.2	14.9	19	33.0%	28.9	24.4	29	-15.6%	32.8	32.1	27	-2.1%
Arizona	14.1	17.4	29	23.4%	22.3	21.2	10	-4.9%	27.7	27.9	6	0.7%
Arkansas	24.4	24.6	45	0.8%	37.7	31.4	42	-16.7%	44.4	39.9	43	-10.1%
California	15.2	19.1	34	25.7%	23.8	24.6	31	3.4%	25.6	28.9	11	12.9%
Colorado	13.5	13.2	9	-2.2%	21.3	20.1	5	-5.6%	31.1	28.9	11	-7.1%
Connecticut	10.2	11.7	1	14.7%	22.1	21.7	11	-1.8%	35.5	27.8	4	-21.7%
Delaware	17.1	16.0	24	-6.4%	23.9	23.4	20	-2.1%	32.9	32.8	32	-0.3%
D.C.	12.1	14.1	16	16.5%	22.1	23.7	23	7.2%	28.5	26.3	1	-7.7%
Florida	16.5	19.9	39	20.6%	25.6	24.1	25	-5.9%	29.2	28.5	8	-2.4%
Georgia	16.7	20.6	40	23.4%	35.7	33.4	46	-6.4%	49.5	41.4	47	-16.4%
Hawaii	13.2	12.5*	6	-5.3%	21.3	19.3*	3	-9.4%	37.3	30.0*	17	-19.6%
Idaho	13.7	15.5	21	13.1%	22.6	24.2	27	7.1%	30.3	30.9	23	2.0%
Illinois	16.0	17.5	30	9.4%	27.3	26.1	35	-4.4%	32.9	32.9	33	0.0%
Indiana	16.5	19.2	36	16.4%	29.2	29.1	38	-0.3%	39.5	35.7	36	-9.6%
Iowa	11.4	12.4	4	8.8%	20.7	19.7	4	-4.8%	29.7	28.7	10	-3.4%
Kansas	12.8	14.1	16	10.2%	22.7	23.5	21	3.5%	39.7	30.8	22	-22.4%
Kentucky	28.1	29.2	49	3.9%	39.3	38.9	50	-1.0%	42.4	46.2	50	9.0%
Louisiana	21.3	23.7	43	11.3%	35.1	32.9	45	-6.3%	42.8	40.3	46	-5.8%
Maine	14.4	15.8	22	9.7%	24.4	24.3	28	-0.4%	28.4	32.2	28	13.4%
Maryland	14.3	14.6	18	2.1%	23.0	23.5	21	2.2%	28.9	30.2	19	4.5%
Massachusetts	13.1	13.4	11	2.3%	21.2	21.1	8	-0.5%	28.7	30.7	21	7.0%
Michigan	16.0	17.2	28	7.5%	28.3	22.5	15	-20.5%	38.2	32.4	29	-15.2%
Minnesota	10.5	11.8	2	12.4%	22.2	18.5	2	-16.7%	31.7	29.6	13	-6.6%
Mississippi	28.2	30.6	51	8.5%	41.5	40.6	51	-2.2%	50.8	48.3	51	-4.9%
Missouri	16.4	19.6	37	19.5%	26.5	31.7	43	19.6%	38.9	37.7	40	-3.1%
Montana	14.8	13.8	14	-6.8%	20.1	23.3	18	15.9%	28.3	28.0	7	-1.1%
Nebraska	12.4	13.7	13	10.5%	21.9	23.7	23	8.2%	39.8	31.6	25	-20.6%
Nevada	16.0	18.8	33	17.5%	26.3	20.9	7	-20.5%	28.9	29.8	14	3.1%
New Hampshire	11.3	12.1	3	7.1%	18.8	22.6	16	20.2%	27.4	27.6	3	0.7%
New Jersey	14.4	16.3	26	13.2%	21.9	24.5	30	11.9%	29.3	31.4	24	7.2%
New Mexico	16.5	19.6	37	18.8%	27.8	27.7	37	-0.4%	31.8	37.1	39	16.7%
New York	14.2	19.1	34	34.5%	22.7	27.1	36	19.4%	38.3	36.4	38	-5.0%
North Carolina	22.0	23.9	44	8.6%	37.2	33.6	47	-9.7%	46.8	40.2	45	-14.1%
North Dakota	15.7	13.5	12	-14.0%	26.1	22.1	13	-15.3%	39.7	34.2	34	-13.9%
Ohio	18.7	16.6	27	-11.2%	28.2	25.2	33	-10.6%	32.9	32.6	31	-0.9%
Oklahoma	18.0	21.5	41	19.4%	28.3	32.2	44	13.8%	39.8	40.0	44	0.5%
Oregon	14.0	18.1	32	29.3%	22.8	22.6	16	-0.9%	27.7	27.1	2	-2.2%
Pennsylvania	14.8	17.5	30	18.2%	25.5	25.4	34	-0.4%	35.3	34.6	35	-2.0%
Rhode Island	18.0	15.8	22	-12.2%	29.2	24.9	32	-14.7%	31.7	29.9	16	-5.7%
South Carolina	22.9	22.8	42	-0.4%	34.2	29.8	39	-12.9%	46.0	35.7	36	-22.4%
South Dakota	15.5	13.2	9	-14.8%	22.3	23.3	18	4.5%	32.6	32.5	30	-0.3%
Tennessee	23.1	27.3	48	18.2%	40.0	31.2	41	-22.0%	40.8	39.2	42	-3.9%
Texas	19.6	24.7	46	26.0%	31.1	30.7	40	-1.3%	36.9	38.0	41	3.0%
Utah	15.5	13.8	14	-11.0%	26.3	21.7	11	-17.5%	34.4	31.6	25	-8.1%
Vermont	13.7	12.4	4	-9.5%	22.2	18.4	1	-17.1%	31.1	27.8	4	-10.6%
Virginia	14.2	16.0	24	12.7%	27.8	24.1	25	-13.3%	34.4	29.8	14	-13.4%
Washington	12.2	15.1	20	23.8%	20.8	21.1	8	1.4%	27.2	30.1	18	10.7%
West Virginia	29.5	29.3	50	-0.7%	38.8	37.7	48	-2.8%	44.7	44.3	48	-0.9%
Wisconsin	11.8	12.6	7	6.8%	21.4	20.5	6	-4.2%	30.8	28.6	9	-7.1%
Wyoming	13.4	13.1	8	-2.2%	22.5	22.1	13	-1.8%	30.6	30.4	20	-0.7%
Median Rate	15.2	16.5		8.2%	25.5	24.2		-5.3%	32.9	31.9		-3.2%

* The data shown represents 2001-2003 survey responses as 2002-2004 data was unavailable.

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System.

Table A10: Death Rates Due to All Causes, Diseases of the Heart, Cancer, Cerebrovascular Diseases, Chronic Lower Respiratory Disease, Diabetes, Influenza and Pneumonia, and Alzheimer's by State, 2003

State	All causes		Diseases of the Heart		Cancer		Cerebrovascular Diseases (Strokes)		Chronic Lower Respiratory Disease		Diabetes		Influenza and Pneumonia		Alzheimer's	
	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
Alabama	1,001.7	49	281.7	47	207.1	45	65.1	45	51.8	41	30.0	41	25.0	36	27.6	43
Alaska	829.8	27	181.8	5	186.4	19	60.7	41	46.1	27	27.3	32	20.5	17	22.2	27
Arizona	787.1	17	198.3	12	172.5	6	44.4	8	46.0	25	20.7	8	23.6	32	31.6	49
Arkansas	937.5	42	258.4	41	204.9	44	69.6	51	49.9	38	29.8	40	30.3	50	18.0	9
California	754.3	5	219.8	26	172.1	5	56.8	30	43.5	21	22.5	12	26.3	45	21.3	20
Colorado	784.3	15	178.0	3	169.2	3	50.7	15	53.7	45	19.0	4	22.5	27	25.9	37
Connecticut	734.6	3	201.8	18	183.0	15	43.5	6	36.0	7	16.7	3	20.1	16	13.9	3
Delaware	844.4	29	243.1	36	201.4	38	49.0	13	40.2	16	28.2	38	15.4	3	18.0	9
D.C.	982.3	47	287.3	49	199.7	37	45.0	10	24.2	2	32.2	48	15.2	2	16.5	4
Florida	776.0	12	212.7	24	181.4	14	43.4	5	39.9	15	21.8	11	13.2	1	18.2	11
Georgia	946.4	43	251.8	39	196.5	32	64.5	44	48.4	36	24.3	19	25.6	40	26.0	38
Hawaii	649.3	1	176.9	2	154.8	2	53.9	23	20.6	1	14.5	1	16.9	7	11.4	2
Idaho	797.1	21	197.0	11	180.3	10	58.8	35	47.2	31	27.8	35	25.5	39	27.1	41
Illinois	834.5	28	235.1	31	197.1	34	54.2	26	39.1	14	24.4	20	22.3	26	20.2	13
Indiana	894.5	37	246.3	37	207.6	46	57.7	34	52.5	42	27.7	33	21.6	23	23.9	33
Iowa	768.4	9	208.1	21	187.3	20	53.7	22	46.4	28	20.0	5	25.7	43	21.6	23
Kansas	824.0	25	212.5	23	186.2	18	56.8	30	49.5	37	23.1	16	21.9	24	24.3	35
Kentucky	977.7	45	275.9	46	223.6	51	60.4	39	58.2	48	31.4	45	25.6	40	27.0	40
Louisiana	1,004.6	50	274.2	45	221.9	50	60.4	39	41.1	17	40.8	51	22.1	25	29.1	46
Maine	822.3	23	200.6	17	204.4	42	51.5	16	51.0	40	26.0	25	21.1	20	29.7	47
Maryland	852.9	34	235.6	32	195.0	29	53.6	21	39.0	13	27.9	36	23.1	31	17.3	7
Massachusetts	778.7	13	198.4	13	193.5	28	45.6	11	38.5	8	20.0	5	26.4	46	20.7	15
Michigan	850.5	32	254.0	40	193.4	27	53.5	20	44.3	22	26.0	25	19.0	13	20.8	17
Minnesota	713.0	2	152.0	1	181.0	12	47.1	12	35.6	6	24.7	22	15.4	3	22.2	27
Mississippi	1,014.0	51	310.3	51	211.1	47	62.1	43	50.1	39	24.1	18	27.2	47	21.1	19
Missouri	902.6	38	262.9	42	202.5	39	57.2	33	47.9	32	27.1	29	25.4	38	20.3	14
Montana	828.1	26	190.7	8	180.9	11	55.1	27	58.0	47	25.5	23	24.1	34	22.2	27
Nebraska	790.5	18	196.9	10	178.5	7	53.9	23	46.7	29	20.9	10	20.6	18	21.7	25
Nevada	924.5	40	242.6	35	202.6	40	57.0	32	62.6	51	15.0	2	23.0	29	19.0	12
New Hampshire	749.8	4	210.8	22	190.5	25	41.8	2	41.9	18	23.2	17	15.9	5	22.2	27
New Jersey	794.8	20	234.8	30	195.6	31	42.2	4	31.5	3	26.9	28	19.3	14	17.1	5
New Mexico	823.8	24	191.5	9	169.6	4	43.7	7	52.9	44	33.0	49	21.1	20	20.9	18
New York	760.1	6	266.0	43	178.7	9	35.1	1	32.9	4	20.7	8	25.6	40	8.8	1
North Carolina	905.8	39	231.9	28	195.4	30	65.6	47	48.2	33	29.2	39	25.2	37	27.6	43
North Dakota	766.6	8	198.5	14	178.6	8	55.4	28	38.8	10	26.8	27	21.2	22	36.2	50
Ohio	889.8	36	247.9	38	204.8	43	55.7	29	48.2	33	30.4	43	18.8	11	23.2	32
Oklahoma	974.3	44	300.1	50	199.1	36	67.6	48	58.6	49	30.2	42	25.8	44	21.5	22
Oregon	808.5	22	181.6	4	192.4	26	65.4	46	48.3	35	27.1	29	15.9	5	28.9	45
Pennsylvania	849.2	30	241.8	34	198.8	35	51.7	17	38.8	10	24.5	21	18.8	11	17.7	8
Rhode Island	786.9	16	227.7	27	190.2	24	42.1	3	38.5	8	20.2	7	19.5	15	21.4	21
South Carolina	934.8	41	234.5	29	203.3	41	69.0	50	46.8	30	28.0	37	23.0	29	27.3	42
South Dakota	790.5	18	208.0	20	189.6	23	49.8	14	42.7	19	22.9	15	22.8	28	17.1	5
Tennessee	982.2	46	273.4	44	212.2	49	67.8	49	52.5	42	31.5	47	31.7	51	26.1	39
Texas	855.7	35	237.8	33	185.6	17	59.7	37	43.4	20	31.4	45	20.9	19	24.2	34
Utah	782.3	14	183.5	6	144.1	1	53.9	23	34.7	5	31.2	44	27.4	48	20.7	15
Vermont	765.3	7	199.3	15	181.3	13	44.9	9	45.5	24	27.2	31	17.2	8	25.1	36
Virginia	850.9	33	218.1	25	196.9	33	59.2	36	44.5	23	22.8	14	23.6	32	22.7	31
Washington	775.9	11	188.6	7	188.8	22	60.8	42	46.0	25	25.8	24	18.3	9	39.9	51
West Virginia	994.9	48	284.6	48	211.8	48	60.2	38	59.0	50	36.9	50	24.8	35	21.6	23
Wisconsin	772.5	10	205.1	19	183.0	15	52.3	18	38.9	12	22.6	13	18.5	10	22.0	26
Wyoming	849.9	31	199.5	16	188.4	21	53.0	19	57.2	46	27.7	33	30.2	49	30.1	48
United States	832.7		232.3		190.1		53.5		43.3		25.3		22.0		21.4	

Source: Donna L. Hoyert, et al., *Deaths: Final Data for 2003*, National Vital Statistics Report, Vol. 54, No. 13, Table 29, National Center for Health Statistics, April 19, 2006.

Table A11: Elderly Disability Rates by State, 2000

State	Male						Female						Total					
	One Disability		Two or More Disabilities		No Disability		One Disability		Two or More Disabilities		No Disability		One Disability		Two or More Disabilities		No Disability	
	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
AL	22.6%	43	25.1%	49	52.2%	47	20.5%	49	30.2%	50	49.3%	50	21.4%	46	28.2%	50	50.5%	50
AK	22.6%	41	22.3%	42	55.1%	42	19.7%	32	27.6%	43	52.7%	41	21.1%	41	25.1%	41	53.8%	42
AZ	21.6%	25	17.6%	18	60.8%	20	19.2%	22	20.9%	14	59.9%	16	20.3%	25	19.4%	17	60.3%	17
AR	23.0%	49	25.1%	48	51.9%	48	20.3%	45	29.2%	47	50.5%	48	21.5%	49	27.4%	48	51.1%	48
CA	21.0%	13	19.2%	31	59.8%	26	19.1%	18	24.7%	36	56.2%	36	19.9%	16	22.4%	36	57.8%	31
CO	21.3%	19	18.2%	25	60.5%	22	18.5%	7	21.8%	22	59.7%	18	19.7%	11	20.3%	22	60.0%	20
CT	19.7%	1	15.6%	2	64.7%	1	17.9%	3	20.4%	10	61.7%	7	18.6%	2	18.4%	7	63.0%	3
DE	21.5%	23	15.5%	1	63.0%	7	17.5%	1	20.8%	13	61.8%	6	19.2%	8	18.5%	9	62.3%	5
DC	19.9%	4	18.8%	29	61.3%	17	20.1%	39	24.8%	37	55.1%	37	20.0%	18	22.5%	37	57.5%	35
FL	21.6%	24	17.2%	12	61.2%	18	19.3%	26	20.8%	12	59.9%	17	20.3%	26	19.2%	11	60.5%	15
GA	21.7%	27	23.3%	44	55.0%	43	20.2%	41	29.0%	45	50.8%	46	20.8%	37	26.7%	44	52.5%	44
HI	21.4%	22	20.2%	36	58.5%	32	18.7%	12	21.1%	17	60.2%	14	19.9%	17	20.7%	25	59.4%	25
ID	22.7%	46	20.3%	37	57.0%	37	19.5%	29	22.5%	26	58.0%	27	20.9%	39	21.5%	30	57.5%	34
IL	20.7%	11	17.7%	19	61.6%	14	19.1%	20	22.8%	29	58.0%	26	19.8%	14	20.7%	26	59.5%	23
IN	22.2%	37	19.5%	33	58.4%	34	20.1%	40	23.3%	30	56.7%	34	21.0%	40	21.7%	31	57.4%	37
IA	21.3%	21	16.5%	7	62.1%	12	19.2%	24	18.5%	3	62.3%	4	20.1%	21	17.7%	3	62.2%	6
KS	22.6%	42	18.1%	22	59.3%	30	20.5%	50	21.5%	20	58.0%	28	21.4%	47	20.1%	20	58.5%	28
KY	23.0%	48	25.4%	50	51.6%	50	20.5%	48	29.5%	49	50.0%	49	21.5%	51	27.8%	49	50.7%	49
LA	22.7%	45	23.6%	45	53.8%	46	20.4%	47	29.0%	44	50.6%	47	21.3%	45	26.8%	45	51.9%	46
ME	22.4%	40	18.6%	27	58.9%	31	19.2%	23	21.9%	23	58.9%	22	20.5%	30	20.5%	24	58.9%	27
MD	20.0%	5	17.3%	13	62.7%	8	18.7%	11	22.8%	28	58.5%	24	19.3%	9	20.5%	23	60.2%	18
MA	19.7%	2	16.7%	10	63.6%	4	17.7%	2	21.1%	16	61.2%	9	18.5%	1	19.3%	13	62.2%	7
MI	21.8%	31	18.7%	28	59.5%	29	19.8%	34	23.8%	34	56.3%	35	20.6%	32	21.7%	32	57.7%	33
MN	20.4%	8	15.9%	4	63.6%	3	18.1%	6	19.1%	5	62.8%	3	19.1%	5	17.7%	4	63.1%	2
MS	23.1%	50	26.8%	51	50.0%	51	20.2%	44	32.6%	51	47.1%	51	21.4%	48	30.3%	51	48.3%	51
MO	22.1%	36	19.6%	34	58.3%	35	19.8%	35	23.5%	31	56.7%	33	20.8%	36	21.9%	33	57.4%	36
MT	21.3%	17	18.5%	26	60.3%	23	19.3%	25	20.2%	9	60.5%	13	20.2%	22	19.4%	16	60.4%	16
NE	20.9%	12	16.1%	5	63.0%	6	18.8%	15	18.3%	2	62.9%	1	19.7%	12	17.4%	1	62.9%	4
NV	22.9%	47	17.4%	16	59.7%	27	19.8%	36	21.0%	15	59.2%	20	21.3%	44	19.3%	12	59.4%	24
NH	21.3%	20	16.4%	6	62.3%	10	19.1%	19	20.1%	8	60.8%	11	20.0%	19	18.5%	8	61.5%	9
NJ	19.8%	3	16.7%	9	63.4%	5	18.6%	9	21.5%	19	59.9%	15	19.1%	4	19.5%	18	61.4%	11
NM	21.8%	33	21.9%	39	56.3%	40	19.5%	27	26.1%	38	54.4%	38	20.5%	28	24.3%	38	55.2%	39
NY	20.0%	6	17.4%	14	62.6%	9	18.5%	8	23.7%	33	57.7%	30	19.1%	6	21.2%	29	59.7%	22
NC	21.3%	18	22.0%	40	56.8%	39	20.2%	42	27.3%	41	52.5%	43	20.6%	33	25.1%	40	54.3%	40
ND	21.6%	26	17.4%	15	61.0%	19	20.0%	38	18.1%	1	62.0%	5	20.7%	34	17.8%	5	61.5%	8
OH	21.2%	16	18.2%	23	60.6%	21	19.5%	30	22.6%	27	57.9%	29	20.2%	24	20.8%	27	59.0%	26
OK	22.6%	44	23.1%	43	54.3%	44	20.6%	51	26.8%	40	52.6%	42	21.5%	50	25.2%	43	53.3%	43
OR	22.4%	39	19.2%	30	58.4%	33	19.1%	21	22.4%	25	58.5%	25	20.5%	29	21.0%	28	58.5%	29
PA	20.7%	10	17.1%	11	62.2%	11	18.8%	14	21.7%	21	59.5%	19	19.6%	10	19.8%	19	60.6%	13
RI	21.7%	29	16.7%	8	61.6%	15	20.2%	43	21.3%	18	58.5%	23	20.8%	38	19.4%	14	59.7%	21
SC	21.8%	32	22.1%	41	56.1%	41	19.8%	33	27.4%	42	52.8%	40	20.6%	31	25.2%	42	54.2%	41
SD	22.2%	38	17.7%	20	60.1%	24	20.3%	46	18.9%	4	60.8%	12	21.1%	42	18.4%	6	60.5%	14
TN	22.1%	35	24.0%	46	54.0%	45	19.8%	37	29.2%	48	50.9%	45	20.8%	35	27.1%	46	52.2%	45
TX	21.7%	28	21.5%	38	56.8%	38	19.5%	28	26.4%	39	54.1%	39	20.4%	27	24.3%	39	55.2%	38
UT	21.1%	15	17.5%	17	61.4%	16	18.7%	10	22.3%	24	59.0%	21	19.7%	13	20.2%	21	60.1%	19
VT	20.7%	9	17.7%	21	61.6%	13	18.0%	4	20.7%	11	61.3%	8	19.1%	7	19.4%	15	61.4%	10
VA	21.0%	14	19.4%	32	59.6%	28	19.0%	17	24.2%	35	56.8%	32	19.9%	15	22.2%	35	57.9%	30
WA	21.8%	34	20.1%	35	58.0%	36	18.8%	13	23.7%	32	57.5%	31	20.1%	20	22.2%	34	57.7%	32
WV	23.3%	51	25.0%	47	51.7%	49	19.7%	31	29.1%	46	51.2%	44	21.2%	43	27.4%	47	51.4%	47
WI	20.1%	7	15.7%	3	64.3%	2	18.0%	5	19.1%	6	62.9%	2	18.9%	3	17.7%	2	63.5%	1
WY	21.7%	30	18.2%	24	60.0%	25	18.9%	16	19.8%	7	61.2%	10	20.2%	23	19.1%	10	60.7%	12
US	21.3%		19.1%		59.6%		19.3%		23.7%		57.0%		20.1%		21.8%		58.1%	

Source: U.S. Census Bureau, Census 2000 Summary File 3, Table PCT26.

Table A12: Cancer Screening Rates by State, 2004

State	Ever had a Sigmoidoscopy or Colonoscopy, Ages 50+		Had a Sigmoidoscopy or Colonoscopy in Past 5 Years, Ages 50+		Had a Pap Smear in Past 3 Years and No Hysterectomy, Women Ages 18+		Had a Clinical Breast Exam in Past 2 Years, Women Ages 40+		Had a Mammogram in Past 2 Years, Women Ages 40+		Had a Mammogram in Past 2 Years, Women Ages 50+	
	Percent	Rank	Percent	Rank	Percent	Rank	Percent	Rank	Percent	Rank	Percent	Rank
Alabama	50.9	31	42.3	31	87.4	16	76.0	37	75.5	20	78.7	23
Alaska	50.6	33	40.9	37	88.8	5	80.6	17	67.0	46	74.5	39
Arizona	52.1	29	42.2	32	85.2	31	77.9	32	75.5	20	81.2	12
Arkansas	47.4	42	37.4	44	81.8	48	73.3	47	66.9	47	70.0	48
California	53.9	22	43.0	29	84.8	34	74.5	41	76.5	13	81.2	12
Colorado	50.0	37	41.3	35	88.3	9	81.8	15	71.3	38	77.4	31
Connecticut	63.7	2	55.7	3	87.8	12	83.9	9	81.1	5	82.9	8
Delaware	62.0	6	53.7	7	87.7	13	84.4	8	82.4	2	84.2	5
D.C.	63.2	3	54.9	4	88.5	7	85.2	6	80.9	6	83.7	7
Florida	56.2	17	49.3	14	84.1	41	78.7	28	76.5	13	82.1	10
Georgia	53.7	25	43.9	26	87.9	10	80.0	22	74.5	27	77.2	33
Idaho	47.3	43	37.8	43	78.8	49	72.5	49	63.9	50	67.6	50
Illinois	49.0	39	39.2	40	87.5	15	79.4	23	76.1	15	78.9	19
Indiana	50.5	35	39.9	39	82.5	46	74.0	45	69.2	40	73.7	40
Iowa	51.6	30	44.1	25	86.0	25	80.1	21	75.2	24	78.1	25
Kansas	49.9	38	41.6	34	86.2	23	80.2	19	76.1	15	79.5	17
Kentucky	47.2	44	40.3	38	85.0	33	75.8	38	75.6	19	77.5	30
Louisiana	44.9	50	38.4	42	85.2	31	74.2	42	74.3	28	77.4	31
Maine	59.2	12	50.6	10	88.8	5	85.9	4	81.9	4	84.7	4
Maryland	62.2	4	54.5	5	89.0	3	86.4	2	79.0	9	82.9	8
Massachusetts	61.2	8	54.1	6	89.3	2	87.6	1	82.5	1	85.2	2
Michigan	60.4	9	50.5	11	86.5	21	82.6	10	78.9	10	81.6	11
Minnesota	66.3	1	56.9	1	87.9	10	85.5	5	80.5	7	85.2	2
Mississippi	46.8	45	37.2	46	84.5	38	72.3	50	66.4	49	69.8	49
Missouri	52.8	27	43.1	28	84.8	34	74.2	42	68.9	42	73.2	44
Montana	52.6	28	41.8	33	86.1	24	78.5	29	71.9	36	77.7	28
Nebraska	46.2	49	37.1	47	85.8	27	79.3	24	76.0	17	78.8	21
Nevada	46.7	46	36.7	49	84.8	34	74.2	42	69.3	39	73.6	42
New Hampshire	62.2	4	53.3	8	89.8	1	84.8	7	80.2	8	84.0	6
New Jersey	56.6	16	49.1	15	84.3	39	78.8	27	74.9	25	77.8	27
New Mexico	50.7	32	41.3	35	84.7	37	76.1	36	69.1	41	73.5	43
New York	56.7	15	47.6	17	85.4	29	80.3	18	75.5	20	78.8	21
North Carolina	54.6	21	48.7	16	88.4	8	82.0	13	77.4	12	80.5	14
North Dakota	53.9	22	43.2	27	83.3	43	78.4	30	72.2	34	76.4	35
Ohio	53.2	26	45.1	20	86.5	21	79.1	25	73.5	30	80.0	15
Oklahoma	46.7	46	35.7	50	82.9	44	73.9	46	67.6	45	72.7	46
Oregon	54.8	20	44.4	23	83.5	42	75.1	40	71.9	36	76.0	37
Pennsylvania	53.9	22	44.4	23	84.3	39	76.7	34	73.4	31	76.2	36
Rhode Island	61.7	7	56.0	2	89.0	3	86.1	3	82.4	2	86.0	1
South Carolina	55.9	19	46.9	19	87.1	20	78.4	30	72.1	35	76.7	34
South Dakota	50.3	36	42.8	30	87.3	18	80.8	16	76.0	17	79.1	18
Tennessee	50.6	33	44.9	21	87.3	18	81.9	14	78.0	11	78.9	19
Texas	48.4	41	38.9	41	82.2	47	73.1	48	67.8	44	72.9	45
Utah	56.0	18	44.6	22	78.2	50	76.5	35	66.6	48	72.0	47
Vermont	58.8	13	49.6	13	87.7	13	82.5	11	74.8	26	77.6	29
Virginia	59.9	10	51.5	9	87.4	16	79.1	25	73.7	29	78.1	25
Washington	57.4	14	47.1	18	85.4	29	80.2	19	72.8	32	78.6	24
West Virginia	46.3	48	37.3	45	82.6	45	75.3	39	72.5	33	75.7	38
Wisconsin	59.5	11	50.3	12	85.7	28	82.2	12	75.5	20	79.7	16
Wyoming	48.5	40	37.1	47	86.0	25	76.9	33	68.2	43	73.7	40

Data for Hawaii is not available.

Source: National Cancer Institute State Cancer Profiles Website, <http://statecancerprofiles.cancer.gov/>, reporting survey data collected from the 2004 Behavioral Risk Factor Surveillance System.

Table A13: Self-Reported Healthy Lifestyle Indicators, Ages 45 to 64, by State (three-year averages)

State	Physical Activity ^a				Unhealthy Eating ^b				Obesity ^c			
	1994-1996	2002-2004	Rank	Percent Change	1994-1996	2001-2003	Rank	Percent Change	1993-1995	2002-2004	Rank	Percent Change
Alabama	61.1	68.1	47	11.5%	31.8	41.5	41	30.5%	19.2	31.5	48	64.1%
Alaska	75.4	77.7	16	3.1%	32.8	38.4	24	17.1%	22.4	28.5	32	27.2%
Arizona	68.5	76.9	23	12.3%	33.8	40.0	32	18.3%	18.2	24.4	12	34.1%
Arkansas	58.6	68.9	45	17.6%	29.3	42.5	43	45.1%	21.7	30.2	44	39.2%
California	75.5	77.2	19	2.3%	30.2	37.3	17	23.5%	17.9	24.6	14	37.4%
Colorado	78.1	82.5	3	5.6%	32.6	37.4	18	14.7%	16.0	19.5	1	21.9%
Connecticut	73.5	81.3	4	10.6%	24.0	30.6	4	27.5%	16.3	22.8	7	39.9%
Delaware	58.3	74.1	31	27.1%	33.5	35.9	15	7.2%	21.8	28.2	30	29.4%
D.C.	55.0	77.1	21	40.2%	28.8	32.5	7	12.8%	17.1	26.1	17	52.6%
Florida	70.7	72.4	40	2.4%	33.4	37.5	19	12.3%	19.4	26.5	21	36.6%
Georgia	50.2	70.7	43	40.8%	30.9	38.5	25	24.6%	18.3	29.3	39	60.1%
Hawaii	73.6	80.6	9	9.5%	31.1	35.0	9	12.5%	13.2	19.8*	2	50.0%
Idaho	74.7	79.1	13	5.9%	33.6	39.5	29	17.6%	17.6	26.2	19	48.9%
Illinois	65.4	73.6	34	12.5%	33.9	53.4	51	57.5%	22.6	28.1	29	24.3%
Indiana	66.3	72.7	39	9.7%	35.3	40.8	36	15.6%	24.5	31.3	46	27.8%
Iowa	67.1	77.3	17	15.2%	35.4	42.0	42	18.6%	21.8	28.0	27	28.4%
Kansas	64.7	74.1	31	14.5%	30.2	42.5	43	40.7%	17.1	28.0	27	63.7%
Kentucky	47.7	68.4	46	43.4%	36.3	35.5	12	-2.2%	20.3	29.0	35	42.9%
Louisiana	62.6	66.2	50	5.8%	37.0	43.5	46	17.6%	22.3	31.5	48	41.3%
Maine	58.5	76.8	25	31.3%	27.3	33.7	8	23.4%	17.9	24.6	14	37.4%
Maryland	64.6	77.2	19	19.5%	30.7	31.4	5	2.3%	20.8	26.1	17	25.5%
Massachusetts	72.6	81	8	11.6%	29.0	30.0	2	3.4%	15.7	22.1	3	40.8%
Michigan	74.2	76.6	26	3.2%	34.5	42.6	45	23.5%	25.5	30.8	45	20.8%
Minnesota	76.3	83.8	1	9.8%	30.3	39.2	28	29.4%	18.3	29.0	35	58.5%
Mississippi	55.7	65.6	51	17.8%	43.3	45.1	50	4.2%	23.8	32.8	50	37.8%
Missouri	66.0	73.2	37	10.9%	32.1	41.2	38	28.3%	23.8	27.5	25	15.5%
Montana	76.6	80.2	11	4.7%	28.7	35.6	14	24.0%	17.2	23.0	9	33.7%
Nebraska	72.8	77.3	17	6.2%	33.4	41.0	37	22.8%	21.6	28.6	34	32.4%
Nevada	74.6	74.9	30	0.4%	37.4	41.4	40	10.7%	15.7	22.9	8	45.9%
New Hampshire	72.1	80.0	12	11.0%	27.3	32.3	6	18.3%	16.9	23.8	11	40.8%
New Jersey	68.8	73.8	33	7.3%	25.4	37.9	21	49.2%	17.1	24.4	12	42.7%
New Mexico	74.4	79.0	14	6.2%	30.2	41.2	38	36.4%	15.2	23.3	10	53.3%
New York	64.2	73.6	34	14.6%	26.3	35.5	12	35.0%	20.4	26.0	16	27.5%
North Carolina	53.7	71.8	41	33.7%	33.6	36.7	16	9.2%	20.0	29.4	40	47.0%
North Dakota	61.3	76.9	23	25.4%	35.2	44.4	49	26.1%	21.4	30.1	42	40.7%
Ohio	55.4	73.3	36	32.3%	33.6	38.1	22	13.4%	21.7	29.4	40	35.5%
Oklahoma	59.7	67.5	48	13.1%	31.8	44.1	48	38.7%	15.8	29.2	38	84.8%
Oregon	77.1	81.1	6	5.2%	32.3	38.2	23	18.3%	19.0	26.2	19	37.9%
Pennsylvania	71.8	75.7	29	5.4%	33.4	40.1	33	20.1%	21.9	29.0	35	32.4%
Rhode Island	72.4	76.4	27	5.5%	30.6	35.3	10	15.4%	18.7	22.5	4	20.3%
South Carolina	62.9	73.2	37	16.4%	31.6	39.8	31	25.9%	21.9	28.5	32	30.1%
South Dakota	63.2	77.1	21	22.0%	31.3	39.0	27	24.6%	18.2	28.4	31	56.0%
Tennessee	57.2	66.5	49	16.3%	26.9	28.2	1	4.8%	19.8	30.1	42	52.0%
Texas	68.1	71.4	42	4.8%	30.1	40.7	35	35.2%	22.4	31.4	47	40.2%
Utah	77.6	80.4	10	3.6%	31.3	43.5	46	39.0%	18.5	27.1	23	46.5%
Vermont	74.9	81.1	6	8.3%	26.1	30.3	3	16.1%	18.6	22.7	6	22.0%
Virginia	70.4	75.8	28	7.7%	29.2	35.4	11	21.2%	18.4	27.4	24	48.9%
Washington	78.6	83.6	2	6.4%	32.6	37.5	19	15.0%	18.6	27.0	22	45.2%
West Virginia	52.8	70.3	44	33.1%	34.1	40.6	34	19.1%	20.7	33.6	51	62.3%
Wisconsin	75.0	81.2	5	8.3%	37.6	38.8	26	3.2%	22.8	27.7	26	21.5%
Wyoming	75.2	79.0	14	5.1%	30.6	39.6	30	29.4%	17.7	22.5	4	27.1%
Median Rate	68.5	76.6		11.8%	31.8	38.8		22.0%	19.0	27.7		45.8%

a Persons who report participating in any physical activity or exercise during the month before interview.

b Persons who report consuming less than 3 servings of fruit or vegetables per day.

c Persons reporting body mass index greater than 30.0.

* The data shown represents 2001-2003 survey responses as 2002-2004 data was unavailable.

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System.

Table A14: Self-Reported Healthy Lifestyle Indicators, Ages 65 and Over, by State (three-year averages)

State	Physical Activity ^a				Unhealthy Eating ^b				Obesity ^c			
	1994-1996	2002-2004	Rank	Percent Change	1994-1996	2001-2003	Rank	Percent Change	1993-1995	2002-2004	Rank	Percent Change
Alabama	46.9	62.7	44	33.7%	27.9	32.4	46	16.1%	16.3	21.0	37	28.8%
Alaska	47.3	65.3	37	38.1%	21.0	30.6	44	45.7%	21.7	22.6	44	4.1%
Arizona	63.6	71.1	8	11.8%	20.2	24.4	17	20.8%	10.4	16.9	5	62.5%
Arkansas	52.8	63.4	42	20.1%	23.3	30.4	42	30.5%	14.1	18.0	8	27.7%
California	75.0	74.6	5	-0.5%	16.2	24.1	14	48.8%	11.9	19.7	24	65.5%
Colorado	71.7	72.6	6	1.3%	21.0	26.6	24	26.7%	8.5	13.4	2	57.6%
Connecticut	62.7	69.9	13	11.5%	15.3	20.1	2	31.4%	10.0	18.3	11	83.0%
Delaware	49.2	65.7	32	33.5%	17.8	27.2	30	52.8%	15.4	21.5	41	39.6%
D.C.	46.5	67.7	25	45.6%	23.7	22.8	10	-3.8%	15.5	22.7	45	46.5%
Florida	68.5	67.8	24	-1.0%	19.0	26.7	26	40.5%	12.0	18.5	14	54.2%
Georgia	39.7	62.3	46	56.9%	25.9	34.7	48	34.0%	12.3	20.9	35	69.9%
Hawaii	73.9	77.1*	2	4.3%	21.4	24.4	17	14.0%	7.5	10.7	1	42.7%
Idaho	67.3	70.4	10	4.6%	20.8	28.5	34	37.0%	12.7	19.6	23	54.3%
Illinois	61.8	63.2	43	2.3%	19.8	43.7	51	120.7%	13.1	21.0	37	60.3%
Indiana	57.0	62.1	47	8.9%	27.8	30.5	43	9.7%	16.0	20.8	34	30.0%
Iowa	60.7	66.6	27	9.7%	19.0	25.3	20	33.2%	16.0	24.2	50	51.3%
Kansas	54.6	65.4	34	19.8%	19.1	26.6	24	39.3%	12.5	18.9	20	51.2%
Kentucky	39.3	60.4	48	53.7%	28.7	28.3	32	-1.4%	12.6	20.0	26	58.7%
Louisiana	51.9	57.5	50	10.8%	29.0	35.3	49	21.7%	17.9	22.8	47	27.4%
Maine	53.1	66.1	30	24.5%	16.5	21.3	5	29.1%	13.2	19.7	24	49.2%
Maryland	51.0	68.0	23	33.3%	22.2	21.2	3	-4.5%	14.5	19.1	21	31.7%
Massachusetts	64.6	69.0	16	6.8%	19.4	22.2	7	14.4%	11.8	18.3	11	55.1%
Michigan	63.3	68.5	17	8.2%	18.7	28.3	32	51.3%	13.0	24.2	50	86.2%
Minnesota	62.7	77.3	1	23.3%	19.2	24.2	16	26.0%	15.3	20.4	31	33.3%
Mississippi	48.7	58.5	49	20.1%	35.5	39.6	50	11.5%	15.5	21.8	42	40.6%
Missouri	58.1	65.3	37	12.4%	21.2	28.8	36	35.8%	12.2	20.0	26	63.9%
Montana	63.5	69.8	14	9.9%	20.5	24.4	17	19.0%	12.0	16.2	4	35.0%
Nebraska	63.5	71.3	7	12.3%	20.0	27.0	29	35.0%	14.9	21.3	40	43.0%
Nevada	68.4	68.4	18	0.0%	23.7	28.6	35	20.7%	11.3	18.6	16	64.6%
New Hampshire	58.2	68.1	21	17.0%	20.1	21.8	6	8.5%	13.3	18.2	10	36.8%
New Jersey	56.0	67.0	26	19.6%	20.5	23.0	11	12.2%	12.2	19.2	22	57.4%
New Mexico	69.3	70.9	9	2.3%	23.9	30.1	40	25.9%	10.4**	15.3	3	47.1%
New York	54.1	64.4	40	19.0%	18.2	25.3	20	39.0%	12.8	20.7	33	61.7%
North Carolina	44.0	65.4	34	48.6%	29.7	30.0	39	1.0%	14.6	20.9	35	43.2%
North Dakota	52.2	65.4	34	25.3%	20.7	24.1	14	16.4%	15.4	24.0	49	55.8%
Ohio	51.9	63.7	41	22.7%	22.2	26.0	23	17.1%	15.4	22.7	45	47.4%
Oklahoma	45.1	62.7	44	39.0%	19.6	30.2	41	54.1%	10.6	18.0	8	69.8%
Oregon	71.4	75.4	3	5.6%	20.7	25.7	22	24.2%	12.0	17.7	6	47.5%
Pennsylvania	60.4	64.7	39	7.1%	20.9	26.7	26	27.8%	14.9	23.0	48	54.4%
Rhode Island	63.2	65.8	31	4.1%	24.0	23.1	12	-3.7%	11.1	18.3	11	64.9%
South Carolina	56.7	69.1	15	21.9%	22.4	29.5	38	31.7%	14.7	20.6	32	40.1%
South Dakota	51.1	68.4	18	33.9%	20.8	21.2	3	1.9%	14.4	20.1	28	39.6%
Tennessee	47.5	56.0	51	17.9%	22.0	22.3	8	1.4%	14.5	18.5	14	27.6%
Texas	60.4	66.4	28	9.9%	23.2	29.4	37	26.7%	12.2	20.1	28	64.8%
Utah	69.0	70.0	12	1.4%	20.8	31.1	45	49.5%	10.1	20.2	30	100.0%
Vermont	65.9	68.1	21	3.3%	16.0	19.5	1	21.9%	11.7	17.9	7	53.0%
Virginia	58.2	66.4	28	14.1%	19.7	23.7	13	20.3%	14.6	18.6	16	27.4%
Washington	74.7	74.7	4	0.0%	20.2	26.8	28	32.7%	12.4	18.7	18	50.8%
West Virginia	43.6	65.7	32	50.7%	27.1	34.0	47	25.5%	13.7	21.0	37	53.3%
Wisconsin	62.9	70.3	11	11.8%	15.5	22.5	9	45.2%	15.2	21.9	43	44.1%
Wyoming	68.5	68.2	20	-0.4%	19.1	28.1	31	47.1%	12.6	18.7	18	48.4%
Median Rate	58.2	67.0		15.1%	20.8	26.7		28.4%	13.1	20.0		52.7%

a Persons who report participating in any physical activity or exercise during the month before interview.

b Persons who report consuming less than 3 servings of fruit or vegetables per day.

c Persons reporting body mass index greater than 30.0.

* The data shown represents 2001-2003 survey responses as 2002-2004 data was unavailable.

** The data shown represents 1994-1996 survey responses as 1993-1995 data was unavailable.

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System.



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